STATE OF NEW YORK

9007--B

IN ASSEMBLY

January 19, 2022

A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, in relation to the implementation of the Nurses Across New York (NANY) program (Part A); intentionally omitted (Part B); to amend part D of chapter 56 of the laws of 2014, amending the education law relating to enacting the "nurse practitioners modernization act", in relation to the effectiveness thereof (Part C); in relation to establishing the health care and mental hygiene worker bonuses (Part D); to amend the public health law, in relation to increasing general public health work base grants for both full-service and partial-service counties and allow for local health departments to claim up to fifty percent of personnel service costs (Part E); intentionally omitted (Part F); intentionally omitted (Part G); to repeal sections 91 and 92 of part H of chapter 59 of the laws of 2011 relating to the year to year rate of growth of Department of Health state funds and Medicaid funding, relating to the state Medicaid spending cap and related processes (Part H); relating to provide a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates (Part I); to amend the public health law, in relation to extending the statutory requirement to reweight and rebase acute hospital rates (Part J); to amend the public health law, in relation to the creation of a new statewide health care facility transformation program (Part K); intentionally omitted (Part L); to amend the public health law, in relation to the definition of revenue in the minimum spending statute for nursing homes and the rates of payment and rates of reimbursement for residential health care facilities, and in relation to making a temporary payment to facilities in severe financial distress (Part M); to amend the social services law, in relation to Medicaid eligibility requirements for seniors and disabled individuals; and to repeal certain provisions of such law relating thereto (Part N); to amend the social services law and the public health law, in relation to providing increased rates for private duty nursing services that are provided to medically frag-

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

ile adults (Part O); intentionally omitted (Part P); to amend the public health law and the social services law, in relation to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent; to amend the social services law, in relation to allowing pregnant individuals to be eligible for the basic health program and maintain coverage in the basic health program for one year post pregnancy and to deem a child born to an individual covered under the basic health program to be eligible for medical assistance; and providing for the repeal of certain provisions upon the expiration thereof (Part Q); intentionally omitted (Part R); to amend the social services law, in relation to including expanded pre-natal and post-partum care as standard coverage when determined to be necessary; and to repeal section 369-hh of the social services law, relating thereto (Part S); intentionally omitted (Part T); to amend the public health law, in relation to updating the definition of the terms "covered health care services" and "premium payment" (Part U); intentionally omitted (Part V); to amend the social services law, in relation to eliminating unnecessary requirements for utilization reviews (Part W); intentionally omitted (Part X); intentionally omitted (Part Y); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending the physicians medical malpractice program; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part Z); intentionally omitted (Part AA); intentionally omitted (Part BB); to amend the social services law, the executive law and the public health law, in relation to extending various provisions relating to health and mental hygiene; to amend part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend part E of chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness thereof; to amend part II of chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, in relation to the effectiveness thereof; to amend chapter 74 of the laws of 2020, relating to directing the department of health to convene a work group on rare diseases, in relation to the effectiveness thereof; and to

amend chapter 414 of the laws of 2018, creating the radon task force, in relation to the effectiveness thereof (Part CC); in relation to establishing a cost of living adjustment for designated human services programs (Part DD); to amend the mental hygiene law, in relation to a 9-8-8 suicide prevention and behavioral health crisis hotline system (Part EE); to amend the social services law, in relation to reinvesting savings recouped from behavioral health transition into managed care back into behavioral health services (Part FF); intentionally omitted (Part GG); intentionally omitted (Part HH); to amend the mental hygiene law, in relation to providing for requirements for recovery living residences (Part II); to amend the mental hygiene law, in relation to expanding the scope of the alcohol awareness program to become the substance use awareness program (Part JJ); intentionally omitted (Part KK); to amend chapter 56 of the laws of 2013 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and referencing the office of addiction services and supports; to amend part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services referencing the office of addiction services and supports and in relation to the effectiveness thereof (Part LL); to amend Kendra's law, in relation to extending the expiration thereof; and to amend the mental hygiene law, in relation to permitting video conferencing for certain physicians regarding assisted outpatient treatment (Part MM); to amend the mental hygiene law, in relation to rental and mortgage payments for the mentally ill (Part NN); to amend part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, in relation to the effectiveness thereof (Part OO); to amend the public health law, in relation to the adult cystic fibrosis assistance program (Part PP); to amend the public health law, in relation to expanding review of correctional health services and health care staffing at correctional facilities (Part QQ); to amend the social services law, in relation to coverage for services provided by school-based health centers for medical assistance recipients; and to amend part JJ of chapter 57 of the laws of 2021 amending the social services law relating to managed care programs, in relation to the effectiveness thereof (Part RR); to amend the social services law, in relation to expanding eligibility for the medicare savings program (Part SS); to amend the public health law and part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund Medicaid expenditures, in relation to fair pay for home care aides (Part TT); and to amend the tax law, in relation to the deposit of certain revenues from taxes into the New York state agency trust fund, distressed provider assistance account; to amend chapter 56 of the laws of 2020 amending the tax law and the social services law relating to certain Medicaid management, in relation to the effectiveness thereof; and to repeal certain provisions of the tax law relating to financially distressed hospitals (Part UU)

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

Section 1. This act enacts into law major components of legislation necessary to implement the state health and mental hygiene budget for the 2022-2023 state fiscal year. Each component is wholly contained within a Part identified as Parts A through UU. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Short title. This act shall be known and may be cited as the "nurses across New York (NANY) program".

§ 2. The public health law is amended by adding a new section 2807-aa to read as follows:

§ 2807-aa. Nurse loan repayment program. 1. (a) Monies shall be made available, subject to appropriations, for purposes of loan repayment awards in accordance with the provisions of this section for registered professional nurses licensed to practice under section sixty-nine hundred five of the education law and licensed practical nurses licensed under section sixty-nine hundred six of the education law. Funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state.

(i) Loan repayment awards made under this section shall be awarded to repay student loans of nurses who work in areas determined to be underserved areas in New York state and who agree to work in such areas for a period of three consecutive years. A nurse may be deemed to be practicing in an underserved area if they practice in a facility, physician's office, nurse practitioner's office, or physician assistant's office that primarily serves an underserved population without regard to whether the population or the facility or office is located in an underserved area. For purposes of this section, "underserved areas" shall be located in New York state and shall include, but not be limited to, areas designated by the federal government as a health professional shortage area, a medically underserved area, or medically underserved population, non-profit diagnostic and treatment centers which primarily serve Medicaid eligible or uninsured patients, and other areas and populations as determined by the commissioner.

(ii) Loan repayment awards made under this section shall not exceed the total qualifying outstanding debt of the nurse from student loans to cover tuition and other related educational expenses, made by or guaranteed by the federal or state government, or made by a lending or educational institution approved under title IV of the federal higher education act. Loan repayment awards shall be used solely to repay outstanding student loan debt.

(iii) Nurses shall be eligible for a loan repayment award to be determined by the commissioner over a three-year period distributed as follows: thirty percent of total award for the first year; thirty percent of total award for the second year; and any unpaid balance of

the total award not to exceed the maximum award amount for the third year.

(iv) In the event that a three-year commitment under this section is not fulfilled, the recipient shall be responsible for repayment of amounts paid which shall be calculated in accordance with the formula set forth in subdivision (b) of section two hundred fifty-four-o of title forty-two of the United States Code, as amended, or any regulations made thereunder.

(b) The commissioner may postpone, change or waive the service obligation and repayment amounts set forth in subparagraphs (i) and (iv) of paragraph (a) of this subdivision in individual circumstances where there is compelling need or hardship.

2. To develop a streamlined application process for the nurse loan repayment program set forth under this section, the department shall appoint a stakeholder work group from recommendations made by associations representing nurses, general hospitals and other health care facilities. Such recommendations shall be made by September thirtieth, two thousand twenty-two.

3. In the event there are undistributed funds within amounts made available for distributions under this section, such funds shall be reallocated and distributed in current or subsequent distribution periods for the purpose set forth in this section.

§ 3. This act shall take effect immediately; provided, however, that section two of this act shall be deemed to have been in full force and effect on and after April 1, 2022.

PART B

Intentionally Omitted

PART C

Section 1. Section 3 of part D of chapter 56 of the laws of 2014, amending the education law relating to enacting the "nurse practitioners modernization act", as amended by section 10 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

§ 3. This act shall take effect on the first of January after it shall have become a law [and shall expire June 30 of the seventh year after it shall have become a law, when upon such date the provisions of this act shall be deemed repealed]; provided, however, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date is authorized and directed to be made and completed on or before such effective date.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART D

Section 1. Short title. This act shall be known and may be cited as the "health care and mental hygiene worker bonuses for state employees" act.

§ 2. Health care and mental hygiene worker bonuses for state employees. 1. An employee who is employed by a state operated facility, an institutional or direct-care setting operated by the executive branch of

the State of New York or a public hospital operated by the state university of New York shall be eligible for the health care and mental hygiene worker bonus. The bonus shall only be paid to employees that receive an annualized base salary of one hundred twenty-five thousand dollars or less. For purposes of this act, "employee" shall mean front-line health care and mental hygiene practitioners, technicians, assistants and aides that provide hands on health or care services to patients, without regard to whether the worker is employed on a full-time, part-time, salaried, hourly, or temporary basis, that received an annualized base salary of one hundred twenty-five thousand dollars or less, to include such titles as determined by the commissioner of health, in consultation with the commissioner of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services.

2. Employees shall be eligible for health care and mental hygiene worker bonuses in an amount up to but not exceeding three thousand dollars per employee. The payment of bonuses shall be paid based on the average number of hours worked during two vesting periods between October first, two thousand twenty-one and March thirty-first, two thousand twenty-three, based on the employee's start date with the employer. No employee's first vesting period may begin later than March thirty-first, two thousand twenty-three, and in total both vesting periods may not exceed one year in duration. For each vesting period, payments shall be in accordance with the following:

(a) employees who have worked an average of at least twenty but less than twenty-seven hours per week over the course of a vesting period shall receive a five hundred dollar bonus for the vesting period;

(b) employees who have worked an average of at least twenty-seven but less than thirty-five hours per week over the course of a vesting period shall receive a one thousand dollar bonus for such vesting period; and

(c) employees who have worked an average of at least thirty-five hours per week over the course of a vesting period shall receive a one thousand five hundred dollar bonus for such vesting period.

3. For the purposes of this section, "vesting period" shall mean a series of six-month periods between the dates of October first, two thousand twenty-one and March thirty-first, two thousand twenty-four for which employees that are continuously employed by an employer during such six-month periods, in accordance with a schedule issued by the commissioner of health or relevant agency commissioner as applicable, may become eligible for a bonus pursuant to subdivision two of this section.

§ 3. An employee under this act shall be limited to a bonus of three thousand dollars per employee.

§ 4. Notwithstanding any provision of law to the contrary, any bonus payment paid under this act, to the extent includible in gross income for federal income tax purposes, shall not be subject to state or local income tax.

§ 5. This act shall take effect immediately.

PART E

Section 1. Subdivision 1 of section 605 of the public health law, as amended by section 20 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

1. A state aid base grant shall be reimbursed to municipalities for the core public health services identified in section six hundred two of this title, in an amount of the greater of [sixty-five] one dollar and thirty cents per capita, for each person in the municipality, or [six hundred fifty thousand dollars] seven hundred fifty thousand dollars, provided that the municipality expends at least [six hundred fifty thousand dollars] seven hundred fifty thousand dollars, for such core public health services. A municipality must provide all the core public health services identified in section six hundred two of this title to qualify for such base grant unless the municipality has the approval of the commissioner to expend the base grant on a portion of such core public health services. If any services in such section are not provided, the commissioner [may] shall limit the municipality's per capita or base grant to reflect the scope of the reduced services, in an amount not to exceed five hundred seventy-seven thousand five hundred dollars. The commissioner may use the amount that is not granted to contract with agencies, associations, or organizations to provide such services; or the health department may use such proportionate share to provide the services upon approval of the director of the division of the budget.

§ 2. Subdivision 2 of section 605 of the public health law, as amended by section 1 of part O of chapter 57 of the laws of 2019, is amended to read as follows:

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made if the municipality is providing some or all of the core public health services identified in section six hundred two of this title, pursuant to an approved application for state aid, at a rate of no less than thirty-six per centum, except for the city of New York which shall receive no less than twenty per centum, of the difference between the amount of moneys expended by the municipality for public health services required by section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. Provided, however, that a municipality's documented fringe benefit costs submitted under an application for state aid and otherwise eligible for reimbursement under this article shall not exceed fifty per centum of the municipality's eligible personnel services. No such reimbursement shall be provided for services that are not eligible for state aid pursuant to this article.

§ 3. Subdivision 2 of section 616 of the public health law, as added by chapter 901 of the laws of 1986, is amended, and a new subdivision 4 is added to read as follows:

2. No payments shall be made from moneys appropriated for the purpose of this article to a municipality for contributions by the municipality for indirect costs [and fringe benefits, including but not limited to, employee retirement funds, health insurance and federal old age and survivors insurance].

4. Moneys appropriated for the purposes of this article to a municipality may include reimbursement of a municipality's fringe benefits, including but not limited to employee retirement funds, health insurance and federal old age and survivor's insurance. However, costs submitted under an application for state aid must be consistent with a municipality's documented fringe benefit costs and shall not exceed fifty per centum of the municipality's eligible personnel services.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART F

Intentionally Omitted

PART G

Intentionally Omitted

PART H

Section 1. Sections 91 and 92 of part H of chapter 59 of the laws of 2011 relating to the year to year rate of growth of Department of Health state funds and Medicaid funding are REPEALED.

§ 2. This act shall take effect immediately.

PART I

Section 1. 1. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2022, and thereafter, all department of health Medicaid payments made for services provided on and after April 1, 2022, shall be subject to a uniform rate increase of one percent, subject to the approval of the commissioner of the department of health and director of the budget. Such rate increase shall be subject to federal financial participation.

2. The following types of payments shall be exempt from increases pursuant to this section:

(a) payments that would violate federal law including, but not limited to, hospital disproportionate share payments that would be in excess of federal statutory caps;

(b) payments made by other state agencies including, but not limited to, those made pursuant to articles 16, 31 and 32 of the mental hygiene law;

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

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

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

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART J

Section 1. Paragraph (c) of subdivision 35 of section 2807-c of the public health law, as amended by section 32 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) The base period reported costs and statistics used for rate-setting for operating cost components, including the weights assigned to diagnostic related groups, shall be updated no less frequently than every four years and the new base period [shall] <u>may</u> be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on or after April first, two thousand fourteen, but no later

than July first, two thousand fourteen; and further provided that the updated base period subsequent to July first, two thousand eighteen shall begin on or after January first, two thousand twenty-four.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART K

Section 1. The public health law is amended by adding a new section 2825-g to read as follows:

§ 2825-g. Health care facility transformation program: statewide IV. 1. A statewide health care facility transformation program is hereby established within the department for the purpose of transforming, redesigning, and strengthening quality health care services in alignment with statewide and regional health care needs, and in the ongoing pandemic response. The program shall also provide funding, subject to lawful appropriation, in support of capital projects that facilitate furthering such transformational goals.

2. The commissioner shall enter into an agreement with the dormitory authority of the state of New York pursuant to section sixteen hundred eighty-r of the public authorities law, which shall apply to this agreement, subject to the approval of the director of the division of the budget, for the purposes of the distribution, and administration of available funds, pursuant to such agreement, and made available pursuant to this section and appropriation. Such funds may be awarded and distributed by the department for grants to health care facilities including but not limited to, hospitals, residential health care facilities, adult care facilities licensed under title two of article seven of the social services law, diagnostic and treatment centers, and clinics licensed or granted an operating certificate pursuant to this chapter or the mental hygiene law, children's residential treatment facilities licensed pursuant to article thirty-one of the mental hygiene law, assisted living programs approved by the department pursuant to section four hundred sixty-one-l of the social services law, behavioral health facilities licensed or granted an operating certificate pursuant to articles thirty-one and thirty-two of the mental hygiene law, home care providers certified or licensed pursuant to article thirty-six of this chapter, primary care providers, community-based programs funded under the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports or through a local governmental unit as defined under article forty-one of the mental hygiene law, family and child service providers licensed under article twenty-nine-I of this chapter, and independent practice associations or organizations. A copy of such agreement, and any amendments thereto, shall be provided by the department to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of the budget no later than thirty days after such agreement is finalized. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding subdivision two of this section or any inconsistent provision of law to the contrary, and upon approval of the director of the budget, the commissioner may, subject to the availability of lawful appropriation, award up to four hundred fifty million dollars of the funds made available pursuant to this section for unfunded project

applications submitted in response to the request for application number 18406 issued by the department on September thirtieth, two thousand twenty-one pursuant to section twenty-eight hundred twenty-five-f of this article. Authorized amounts to be awarded pursuant to applications submitted in response to the request for application number 18406 shall be awarded no later than December thirty-first, two thousand twenty-two. Provided, however, that a minimum of:

(a) at least one hundred million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; independent practice associations or organizations; a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law; a home care provider certified or licensed pursuant to article thirty-six of this chapter; primary care providers, or hospices licensed or granted an operating certificate pursuant to article forty of this chapter; a mental health outpatient provider licensed or granted an operating certificate under article thirty-one of the mental hygiene law, a substance use disorder treatment provider licensed or granted an operating certificate under article thirty-two of the mental hygiene law, a program licensed under article forty-one of the mental hygiene law, a community-based program funded under the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports or through a local governmental unit as defined under article forty-one of the mental hygiene law, or a family and child service provider licensed under article twenty-nine-I of this chapter; and

(b) fifty million dollars of total awarded funds shall be made to residential health care facilities or adult care facilities.

4. Up to two hundred million dollars of the funds appropriated for this program shall be awarded for grants to health care providers for purposes of modernization of an emergency department of regional significance. For purposes of this subdivision, an emergency department shall be considered to have regional significance if it: (a) serves as Level 1 trauma center with the highest volume in its region; (b) includes the capacity to segregate patients with communicable diseases, trauma or severe behavioral health issues from other patients in the emergency department; (c) provides training in emergency care and trauma care to residents from multiple hospitals in the region; and (d) serves a high proportion of Medicaid patients.

5. (a) Up to seven hundred fifty million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request for proposal process, for grants to health care providers (hereafter "applicants").

(b) Awards made pursuant to this subdivision shall provide funding only for capital projects, to the extent lawful appropriation and funding is available, to build innovative, patient-centered models of care, increase access to care, to improve the quality of care and to ensure financial sustainability of health care providers.

6. Up to one hundred fifty million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request

for proposal process, for technological and telehealth transformation projects.

7. Up to fifty million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or a request for proposal process, to residential and community-based alternatives to the traditional model of nursing home care.

8. Disbursement of awards may be contingent on achieving certain process and performance metrics and milestones that are structured to ensure that the goals of the project are achieved. Awardees shall be notified whether section two hundred twenty or two hundred twenty-four-a of the labor law apply to any construction work that may be performed for projects funded under this section.

9. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, and senate and assembly health committees, until such time as the department determines that the projects that receive funding pursuant to this section are substantially complete. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the applicant, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant to subdivision six of this section.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART L

Intentionally Omitted

PART M

Section 1. Paragraph (d) of subdivision 2-c of section 2808 of the public health law, as amended by section 26-a of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(d) The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision. Such regulations shall be developed in consultation with the nursing home industry and advocates for residential health care facility residents and, further, the commissioner shall provide notification concerning such regulations to the chairs of the senate and assembly health committees, the chair of the senate finance committee and the chair of the assembly ways and means committee. Such regulations shall include provisions for rate adjustments or payment enhancements to facilitate a minimum four-year transition of facilities to the rate-setting methodology established by this subdivision and may also include, but not be limited to, provisions for facilitating quality improvements in residential health care facilities. For purposes of facilitating quality improvements through the establishment of a nursing home quality pool to be funded at the discretion of the commissioner by (i) adjustments in medical assistance rates, (ii) funds made available through state appropriations, or (iii) a combination thereof, those facilities that contribute to the quality pool, but are deemed ineligible for quality pool payments due exclusively to a specific case of employee misconduct, shall nevertheless be eligible for a quality pool payment if the facility properly reported the incident, did not receive a survey citation

from the commissioner or the Centers for Medicare and Medicaid Services establishing the facility's culpability with regard to such misconduct and, but for the specific case of employee misconduct, the facility would have otherwise received a quality pool payment. Regulations pertaining to the facilitation of quality improvement may be made effective for periods on and after January first, two thousand thirteen.

§ 2. The opening paragraph and paragraph (i) of subdivision (g) of section 2826 of the public health law, as added by section 6 of part J of chapter 60 of the laws of 2015, are amended to read as follows:

Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand [fifteen] twenty-two through March thirty-first, two thousand [sixteen] twenty-three, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible [general hospitals] facilities in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services.

(i) Eligible [general hospitals] facilities shall include:

(A) a public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation;

(B) a federally designated critical access hospital;

(C) a federally designated sole community hospital; [or]

(D) a residential health care facility;

(E) adult care facility; or

(F) a general hospital that is a safety net hospital, which for purpose of this subdivision shall mean:

(1) such hospital has at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(G) an independent practice association or accountable care organization authorized under applicable regulations that participate in managed care provider network arrangements with any of the provider types in subparagraphs (A) through (F) of this paragraph.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART N

Section 1. Subparagraph 4 of paragraph (b) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(4) An individual who is a pregnant woman or is a member of a family that contains a dependent child living with a parent or other caretaker relative is eligible for standard coverage if [his or her MAGI] their MAGI household income does not exceed the MAGI-equivalent of one hundred [thirty] thirty-three percent of the [highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program as it existed on the first day of Novem-

ber, nineteen hundred ninety-seven] federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the Secretary of the United States department of health and human services; for purposes of this subparagraph, the term dependent child means a person who is under eighteen years of age, or is eighteen years of age and a full-time student, who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by reason of the unemployment of the parent, as defined by the department of health.

§ 2. Subparagraph 2 of paragraph (c) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(2) An individual who, although not receiving public assistance or care for [his or her] their maintenance under other provisions of this chapter, has income [and resources], including available support from responsible relatives, that does not exceed the amounts set forth in paragraph (a) of subdivision two of this section, and is (i) sixty-five years of age or older, or certified blind or certified disabled or (ii) for reasons other than income or resources, is eligible for federal supplemental security income benefits and/or additional state payments.

§ 3. Subparagraph 5 of paragraph (c) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

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

§ 4. Subparagraph 10 of paragraph (c) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(10) A resident of a home for adults operated by a social services district, or a residential care center for adults or community residence operated or certified by the office of mental health, and has not, according to criteria promulgated by the department consistent with this title, sufficient income, or in the case of a person sixty-five years of age or older, certified blind, or certified disabled, sufficient income [and resources], including available support from responsible relatives, to meet all the costs of required medical care and services available under this title.

§ 5. Paragraph (a) of subdivision 2 of section 366 of the social services law, as separately amended by chapter 32 and 588 of the laws of 1968, the opening paragraph as amended by chapter 41 of the laws of

1992, subparagraph 1 as amended by section 27 of part C of chapter 109 of the laws of 2006, subparagraphs 3 and 6 as amended by chapter 938 of the laws of 1990, subparagraph 4 as amended by section 43 and subparagraph 7 as amended by section 47 of part C of chapter 58 of the laws of 2008, subparagraph 5 as amended by chapter 576 of the laws of 2007, subparagraph 9 as amended by chapter 110 of the laws of 1971, subparagraph 10 as added by chapter 705 of the laws of 1988, clauses (i) and (ii) of subparagraph 10 as amended by chapter 672 of the laws of 2019, clause (iii) of subparagraph 10 as amended by chapter 170 of the laws of 1994, and subparagraph 11 as added by chapter 576 of the laws of 2015, is amended to read as follows:

(a) The following [income and resources] shall be exempt and shall not be taken into consideration in determining a person's eligibility for medical care, services and supplies available under this title:

(1) (i) for applications for medical assistance filed on or before December thirty-first, two thousand five, a homestead which is essential and appropriate to the needs of the household;

(ii) for applications for medical assistance filed on or after January first, two thousand six, a homestead which is essential and appropriate to the needs of the household; provided, however, that in determining eligibility of an individual for medical assistance for nursing facility services and other long term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the homestead exceeds seven hundred fifty thousand dollars; provided further, that the dollar amount specified in this clause shall be increased, beginning with the year two thousand eleven, from year to year, in an amount to be determined by the secretary of the federal department of health and human services, based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest one thousand dollars. If such secretary does not determine such an amount, the department of health shall increase such dollar amount based on such increase in the consumer price index. Nothing in this clause shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the homestead. The home equity limitation established by this clause shall be waived in the case of a demonstrated hardship, as determined pursuant to criteria established by such secretary. The home equity limitation shall not apply if one or more of the following persons is lawfully residing in the individual's homestead: (A) the spouse of the individual; or (B) the individual's child who is under the age of twenty-one, or is blind or permanently and totally disabled, as defined in section 1614 of the federal social security act.

(2) [essential personal property;

(3) a burial fund, to the extent allowed as an exempt resource under the cash assistance program to which the applicant is most closely related;

(4) savings in amounts equal to one hundred fifty percent of the income amount permitted under subparagraph seven of this paragraph, provided, however, that the amounts for one and two person households shall not be less than the amounts permitted to be retained by households of the same size in order to qualify for benefits under the federal supplemental security income program;

(5)] (i) such income as is disregarded or exempt under the cash assistance program to which the applicant is most closely related for purposes of this subparagraph, cash assistance program means either the aid to dependent children program as it existed on the sixteenth day of

July, nineteen hundred ninety-six, or the supplemental security income program; and

(ii) such income of a disabled person (as such term is defined in section 1614(a)(3) of the federal social security act (42 U.S.C. section 1382c(a)(3)) or in accordance with any other rules or regulations established by the social security administration), that is deposited in trusts as defined in clause (iii) of subparagraph two of paragraph (b) of this subdivision in the same calendar month within which said income is received;

[(6)] (3) health insurance premiums;

[(7)] (4) income based on the number of family members in the medical assistance household, as defined in regulations by the commissioner consistent with federal regulations under title XIX of the federal social security act [and calculated as follows:

(i) The amounts for one and two person households and families shall be equal to twelve times the standard of monthly need for determining eligibility for and the amount of additional state payments for aged, blind and disabled persons pursuant to section two hundred nine of this article rounded up to the next highest one hundred dollars for eligible individuals and couples living alone, respectively.

(ii) The amounts for households of three or more shall be calculated by increasing the income standard for a household of two, established pursuant to clause (i) of this subparagraph, by fifteen percent for each additional household member above two, such that the income standard for a three-person household shall be one hundred fifteen percent of the income standard for a two-person household, the income standard for a four-person household shall be one hundred thirty percent of the income standard for a two-person household, and so on.

(iii)] that does not exceed one hundred thirty-eight percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the United States secretary for health and human services and with other provisions of this section.

(5) No other income [or resources], including federal old-age, survivors and disability insurance, state disability insurance or other payroll deductions, whether mandatory or optional, shall be exempt and all other income [and resources] shall be taken into consideration and required to be applied toward the payment or partial payment of the cost of medical care and services available under this title, to the extent permitted by federal law.

[(9) Subject to subparagraph eight, the] (6) The department, upon the application of a local social services district, after passage of a resolution by the local legislative body authorizing such application, may adjust the income exemption based upon the variations between cost of shelter in urban areas and rural areas in accordance with standards prescribed by the United States secretary of health, education and welfare.

[(10)] (7) (i) A person who is receiving or is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:

(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law, the amount of fifty-five dollars per month;

(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office for people with developmental disabilities or a patient of a hospital operated by the office of

mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law, the amount of thirty-five dollars per month.

(ii) A person who neither receives nor is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:

(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law, the amount of fifty dollars per month;

(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office for people with developmental disabilities or a patient of a hospital operated by the office of mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law, the amount of thirty-five dollars per month.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the personal needs allowance for a person who is a veteran having neither a spouse nor a child, or a surviving spouse of a veteran having no child, who receives a reduced pension from the federal veterans administration, and who is a resident of a nursing facility, as defined in section 1919 of the federal social security act, shall be equal to such reduced monthly pension but shall not exceed ninety dollars per month.

[(11)] (8) subject to the availability of federal financial participation, any amount, including earnings thereon, in a qualified NY ABLE account as established pursuant to article eighty-four of the mental hygiene law, any contributions to such NY ABLE account, and any distribution for qualified disability expenses from such account; provided however, that such exemption shall be consistent with section 529A of the Internal Revenue Code of 1986, as amended.

§ 6. Subparagraphs 1 and 2 of paragraph (b) of subdivision 2 of section 366 of the social services law, subparagraph 1 as amended by chapter 638 of the laws of 1993 and as designated by chapter 170 of the laws of 1994, subparagraph 2 as added by chapter 170 of the laws of 1994, clause (iii) of subparagraph 2 as amended by chapter 187 of the laws of 2017, clause (iv) of subparagraph 2 as amended by chapter 656 of the laws of 1997 and as further amended by section 104 of part A of chapter 62 of the laws of 2011, and clause (vi) of subparagraph 2 as added by chapter 435 of the laws of 2018, are amended to read as follows:

(1) In establishing standards for determining eligibility for and amount of such assistance, the department shall take into account only such income [and resources], in accordance with federal requirements, as [are] is available to the applicant or recipient and as would not be required to be disregarded or set aside for future needs, and there shall be a reasonable evaluation of any such income [or resources]. The department shall not consider the availability of an option for an accelerated payment of death benefits or special surrender value pursuant to paragraph one of subsection (a) of section one thousand one hundred thirteen of the insurance law, or an option to enter into a viatical settlement pursuant to the provisions of article seventy-eight of the insurance law, as an available resource in determining eligibility for an amount of such assistance, provided, however, that the payment of such benefits shall be considered in determining eligibility for and amount of such assistance. There shall not be taken into consideration the financial responsibility of any individual for any applicant or recipient of assistance under this title unless such applicant or recipient is such individual's spouse or such individual's child who is

under twenty-one years of age. In determining the eligibility of a child who is categorically eligible as blind or disabled, as determined under regulations prescribed by the social security act for medical assistance, the income [and resources] of parents or spouses of parents are not considered available to that child if she/he does not regularly share the common household even if the child returns to the common household for periodic visits. In the application of standards of eligibility with respect to income, costs incurred for medical care, whether in the form of insurance premiums or otherwise, shall be taken into account. Any person who is eligible for, or reasonably appears to meet the criteria of eligibility for, benefits under title XVIII of the federal social security act shall be required to apply for and fully utilize such benefits in accordance with this chapter.

(2) In evaluating the income [and resources] available to an applicant for or recipient of medical assistance, for purposes of determining eligibility for and the amount of such assistance, the department must consider assets [held in or] paid from trusts created by such applicant or recipient, as determined pursuant to the regulations of the department, in accordance with the provisions of this subparagraph.

(i) In the case of a revocable trust created by an applicant or recipient, as determined pursuant to regulations of the department[: the trust corpus must be considered to be an available resource;], payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

(ii) In the case of an irrevocable trust created by an applicant or recipient, as determined pursuant to regulations of the department: any portion of the trust corpus, and of the income generated by the trust corpus, from which no payment can under any circumstances be made to such applicant or recipient must be considered, as of the date of establishment of the trust, or, if later, the date on which payment to the applicant or recipient is foreclosed, to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section; [any portion of the trust corpus, and of the income generated by the trust corpus, from which payment could be made to or for the benefit of such applicant or recipient must be considered to be an available resource;] payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, in the case of an applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act, the department must not consider as available income [or resources] the [corpus or] income of the following trusts which comply with the provisions of the regulations authorized by clause (iv) of this subparagraph: (A) a trust containing the assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age by the individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual; (B) and a trust containing

the assets of such a disabled individual established and managed by a non-profit association which maintains separate accounts for the benefit of disabled individuals, but, for purposes of investment and management of trust funds, pools the accounts, provided that accounts in the trust fund are established solely for the benefit of individuals who are disabled as such term is defined in section 1614(a)(3) of the federal social security act by such disabled individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, and to the extent that amounts remaining in the individual's account are not retained by the trust upon the death of the individual, the state will receive all such remaining amounts up to the total value of all medical assistance paid on behalf of such individual. Notwithstanding any law to the contrary, a not-for-profit corporation may, in furtherance of and as an adjunct to its corporate purposes, act as trustee of a trust for persons with disabilities established pursuant to this subclause, provided that a trust company, as defined in subdivision seven of section one hundred-c of the banking law, acts as co-trustee.

(iv) The department shall promulgate such regulations as may be necessary to carry out the provisions of this subparagraph. Such regulations shall include provisions for: assuring the fulfillment of fiduciary obligations of the trustee with respect to the remainder interest of the department or state; monitoring pooled trusts; applying this subdivision to legal instruments and other devices similar to trusts, in accordance with applicable federal rules and regulations; and establishing procedures under which the application of this subdivision will be waived with respect to an applicant or recipient who demonstrates that such application would work an undue hardship on him or her, in accordance with standards specified by the secretary of the federal department of health and human services. Such regulations may require: notification of the department of the creation or funding of such a trust for the benefit of an applicant for or recipient of medical assistance; notification of the department of the death of a beneficiary of such a trust who is a current or former recipient of medical assistance; in the case of a trust, the corpus of which exceeds one hundred thousand dollars, notification of the department of transactions tending to substantially deplete the trust corpus; notification of the department of any transactions involving transfers from the trust corpus for less than fair market value; the bonding of the trustee when the assets of such a trust equal or exceed one million dollars, unless a court of competent jurisdiction waives such requirement; and the bonding of the trustee when the assets of such a trust are less than one million dollars, upon order of a court of competent jurisdiction. The department, together with the department of financial services, shall promulgate regulations governing the establishment, management and monitoring of trusts established pursuant to subclause (B) of clause (iii) of this subparagraph in which a not-for-profit corporation and a trust company serve as co-trustees.

(v) Notwithstanding any acts, omissions or failures to act of a trustee of a trust which the department or a local social services official has determined complies with the provisions of clause (iii) and the regulations authorized by clause (iv) of this subparagraph, the department must not consider the [corpus or] income of any such trust as available income [or resources] of the applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act. The department's remedy for redress of any acts, omissions or failures to act by such a trustee which acts, omissions or failures are considered by the department to be inconsistent with the

terms of the trust, contrary to applicable laws and regulations of the department, or contrary to the fiduciary obligations of the trustee shall be the commencement of an action or proceeding under subdivision one of section sixty-three of the executive law to safeguard or enforce the state's remainder interest in the trust, or such other action or proceeding as may be lawful and appropriate as to assure compliance by the trustee or to safeguard and enforce the state's remainder interest in the trust.

(vi) The department shall provide written notice to an applicant for or recipient of medical assistance who is or reasonably appears to be eligible for medical assistance except for having income exceeding applicable income levels. The notice shall inform the applicant or recipient, in plain language, that in certain circumstances the medical assistance program does not count the income of disabled applicants and recipients if it is placed in a trust described in clause (iii) of this subparagraph. The notice shall be included with the eligibility notice provided to such applicants and recipients and shall reference where additional information may be found on the department's website. This clause shall not be construed to change any criterion for eligibility for medical assistance.

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

(a) Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income [and resources] to provide medical assistance as determined by the regulations of the department, the income [and resources] of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three <u>of this chapter</u> and other applicable provisions of law.

§ 8. Paragraph h of subdivision 6 of section 366 of the social services law, as amended by section 69-b of part C of chapter 58 of the laws of 2008, is amended to read as follows:

h. Notwithstanding any other provision of this chapter or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph b of this subdivision, the income [and resources] of responsible relatives shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

§ 9. Subparagraph (vii) of paragraph b of subdivision 7 of section 366 of the social services law, as amended by chapter 324 of the laws of 2004, is amended to read as follows:

(vii) be ineligible for medical assistance because the income [and resources] of responsible relatives are deemed available to him or her, causing him or her to exceed the income or resource eligibility level for such assistance;

§ 10. Paragraph j of subdivision 7 of section 366 of the social services law, as amended by chapter 324 of the laws of 2004, is amended to read as follows:

j. Notwithstanding any other provision of this chapter other than subdivision six of this section or any other law to the contrary, for purposes of determining medical assistance eligibility for persons spec-

ified in paragraph b of this subdivision, the income [and resources] of a responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

§ 11. Subdivision 8 of section 366 of the social services law, as added by chapter 41 of the laws of 1992, is amended to read as follows:

8. Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, income [and resources] which are otherwise exempt from consideration in determining a person's eligibility for medical care, services and supplies available under this title, shall be considered available for the payment or part payment of the costs of such medical care, services and supplies as required by federal law and regulations.

§ 12. Subparagraph (vi) of paragraph b of subdivision 9 of section 366 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

(vi) be eligible or, if discharged, would be eligible for medical assistance, or are ineligible for medical assistance because the income [and resources] of responsible relatives are or, if discharged, would be deemed available to such persons causing them to exceed the income [or resource] eligibility level for such assistance;

§ 13. Paragraph k of subdivision 9 of section 366 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

k. Notwithstanding any provision of this chapter other than subdivision six or seven of this section, or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraphs b and c of this subdivision, the income [and resources] of a responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

§ 14. Paragraph (d) of subdivision 12 of section 366 of the social services law, as added by section 1 of part E of chapter 58 of the laws of 2006, is amended to read as follows:

(d) Notwithstanding any provision of this chapter or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph (b) of this subdivision, the income [and resources] of a legally responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision; provided, however, that such income shall continue to be deemed unavailable should responsibility for the care and placement of the person be returned to [his or her] <u>their</u> parent or other legally responsible person.

§ 15. Paragraph (b) of subdivision 2 of section 366-a of the social services law is REPEALED and paragraphs (c) and (d), paragraph (d) as added by section 29 of part B of chapter 58 of the laws of 2010, are relettered paragraphs (b) and (c).

§ 16. Paragraph (c) of subdivision 2 of section 366-a of the social services law, as added by section 29 of part B of section 58 of the laws of 2010 and as relettered by section fifteen of this act, is amended to read as follows:

(c) Notwithstanding the provisions of paragraph (a) of this subdivision, an applicant or recipient [whose eligibility under this title is determined without regard to the amount of his or her accumulated resources] may attest to the amount of interest income generated by [such] resources if the amount of such interest income is expected to be immaterial to medical assistance eligibility, as determined by the commissioner of health. In the event there is an inconsistency between

the information reported by the applicant or recipient and any information obtained by the commissioner of health from other sources and such inconsistency is material to medical assistance eligibility, the commissioner of health shall request that the applicant or recipient provide adequate documentation to verify [his or her] <u>their</u> interest income.

§ 17. Paragraph (d) of subdivision 2 of section 366-a of the social services law, as amended by chapter 535 of the laws of 2010, is REPEALED.

§ 18. Paragraph (a) of subdivision 8 of section 366-a of the social services law, as amended by section 7 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(a) Notwithstanding subdivisions two and five of this section, information concerning income [and resources] of applicants for and recipients of medical assistance may be verified by matching client information with information contained in the wage reporting system established by section one hundred seventy-one-a of the tax law and in similar systems operating in other geographically contiguous states, by means of an income verification performed pursuant to a memorandum of understanding with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law, and, to the extent required by federal law, with information contained in the non-wage income file maintained by the United States internal revenue service, in the beneficiary data exchange maintained by the United States department of health and human services, and in the unemployment insurance benefits file. Such matching shall provide for procedures which document significant inconsistent results of matching activities. Nothing in this section shall be construed to prohibit activities the department reasonably believes necessary to conform with federal requirements under section one thousand one hundred thirty-seven of the social security act.

§ 19. Subdivision 1 of section 366-c of the social services law, as added by chapter 558 of the laws of 1989, is amended to read as follows:

1. Notwithstanding any other provision of law to the contrary, in determining the eligibility for medical assistance of a person defined as an institutionalized spouse, the income [and resources] of such person and the person's community spouse shall be treated as provided in this section.

§ 20. Paragraphs (c), (d) and (e) of subdivision 2 of section 366-c of the social services law are REPEALED and paragraphs (f), (g), (h), (i), (j) and (k) of subdivision 2 are relettered paragraphs (c), (d), (e), (f), (g) and (h).

§ 21. Subdivisions 5 and 6 of section 366-c of the social services law are REPEALED and subdivisions 7 and 8 are renumbered subdivisions 5 and 6.

§ 22. Subdivisions 5 and 6 of section 366-c of the social services law, as added by chapter 558 of the laws of 1989 and as relettered by section twenty-one of this act, are amended to read as follows:

5. (a) At the beginning or after the commencement of a continuous period of institutionalization, either spouse may request [an assessment of the total value of their resources or] a determination of the community spouse monthly income allowance, the amount of the family allowance, or the method of computing the amount of the family allowance, or the method of computing the amount of the community spouse income allowance.

(b) (i) [Upon receipt of a request pursuant to paragraph (a) of this subdivision together with all relevant documentation of the resources of

both spouses, the social services district shall assess and document the total value of the spouses' resources and provide each spouse with a copy of the assessment and the documentation upon which it was based. If the request is not part of an application for medical assistance benefits, the social services district may charge a fee for the assessment which is related to the cost of preparing and copying the assessment and documentation which fee may not exceed twenty-five dollars.

(ii)] The social services district shall also notify each requesting spouse of the community spouse monthly income allowance, of the amount, if any, of the family allowances, and of the method of computing the amount of the community spouse monthly income allowance.

[(c)]<u>(ii)</u> The social services district shall also provide to the spouse a notice of the right to a fair hearing at the time of provision of the information requested under paragraph (a) of this subdivision or after a determination of eligibility for medical assistance. Such notice shall be in the form prescribed or approved by the commissioner and include a statement advising the spouse of the right to a fair hearing under this section.

6. (a) If, after a determination on an application for medical assistance has been made, either spouse is dissatisfied with the determination of the community spouse monthly allowance[,] <u>or</u> the amount of monthly income otherwise available to the community spouse, [the computation of the spousal share of resources, the attribution of resources or the determination of the community spouse's resource allocation,] the spouse may request a fair hearing to dispute such determination. Such hearing shall be held within thirty days of the request therefor.

(b) If either spouse establishes that the community spouse needs income above the level established by the social services district as the minimum monthly maintenance needs allowance, based upon exceptional circumstances which result in significant financial distress (as defined by the commissioner in regulations), the department shall substitute an amount adequate to provide additional necessary income from the income otherwise available to the institutionalized spouse.

[(c) If either spouse establishes that income generated by the community spouse resource allowance, established by the social services district, is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, the department shall establish a resource allowance for the spousal share of the institutionalized spouse adequate to provide such minimum monthly maintenance needs allowance.]

§ 23. The commissioner of health shall, consistent with the social services law, make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three of the social services law, in order to ensure federal financial participation in expenditures under the provisions of this act. The provisions of this act shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of services provide hereunder.

§ 24. This act shall take effect January 1, 2023, subject to federal financial participation; provided, however that the amendments to paragraph h of subdivision 6 of section 366 of the social services law made by section eight of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith; provided further that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of federal financial participation in

order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART O

Section 1. Subdivisions 2 and 3 of section 367-r of the social services law, subdivision 2 as amended and subdivision 3 as added by section 2 of part PP of chapter 56 of the laws of 2020, are amended to read as follows:

2. Medically fragile children and adults. (a) In addition, the commissioner shall further increase rates for private duty nursing services that are provided to medically fragile children to ensure the availability of such services to such children. Furthermore, no later than sixty days after the chapter of the laws of two thousand twenty-two that amended this subdivision takes effect, increased rates shall be extended for private duty nursing services provided to medically fragile adults. In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children and adults in a non-institutional setting as compared to an institutional setting. Medically fragile children shall, for the purposes of this subdivision, have the same meaning as in subdivision three-a of section thirty-six hundred fourteen of the public health law. For purposes of this subdivision, "medically fragile adult" shall be defined as any individual who previously qualified as a medically fragile child but no longer meets the age requirement. Such increased rates for services rendered to such children and adults may take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the private duty nursing service is provided, costs associated with the provision of private duty nursing services to medically fragile children and adults, and the need for incentives to improve services and institute economies and such increased rates shall be payable only to those private duty nurses who can demonstrate, to the satisfaction of the department of health, satisfactory training and experience to provide services to such children and adults. Such increased rates shall be determined based on application of the case mix adjustment factor for AIDS home care program services rates as determined pursuant to applicable regulations of the department of health. The commissioner may promulgate regulations to implement the provisions of this subdivision.

(b) Private duty nursing services providers which have their rates adjusted pursuant to paragraph (b) of subdivision one of this section and paragraph (a) of this subdivision shall use such funds solely for the purposes of recruitment and retention of private duty nurses or to ensure the delivery of private duty nursing services to medically fragile children and adults and are prohibited from using such funds for any other purpose. Funds provided under paragraph (b) of subdivision one of this section and paragraph (a) of this subdivision are not intended to supplant support provided by a local government. Each such provider, with the exception of self-employed private duty nurses, shall submit, at a time and in a manner to be determined by the commissioner of health, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of private duty nurses or to ensure the delivery of private duty nursing services to

medically fragile children and adults. The commissioner of health is authorized to audit each such provider to ensure compliance with the written certification required by this subdivision and shall recoup all funds determined to have been used for purposes other than recruitment and retention of private duty nurses or the delivery of private duty nursing services to medically fragile children and adults. Such recoupment shall be in addition to any other penalties provided by law.

(c) The commissioner of health shall, subject to the provisions of paragraph (b) of this subdivision, and the provisions of subdivision three of this section, and subject to the availability of federal financial participation, annually increase fees for the fee-for-service reimbursement of private duty nursing services provided to medically fragile children by fee-for-service private duty nursing services providers who enroll and participate in the provider directory pursuant to subdivision three of this section, over a period of three years, commencing October first, two thousand twenty, by one-third annual increments, until such fees for reimbursement equal the final benchmark payment designed to ensure adequate access to the service. In developing such benchmark the commissioner of health may utilize the average two thousand eighteen Medicaid managed care payments for reimbursement of such private duty nursing services. The commissioner may promulgate regulations to implement the provisions of this paragraph.

(d) The commissioner of health shall, subject to the provisions of paragraph (b) of this subdivision, and the provisions of subdivision three of this section, and subject to the availability of federal financial participation, increase fees for the fee-for-service reimbursement of private duty nursing services provided to medically fragile adults by fee-for-service private duty nursing services providers who enroll and participate in the provider directory pursuant to subdivision three of this section, no later than sixty days after the chapter of the laws of two thousand twenty-two that amended this subdivision takes effect, so such fees for reimbursement equal the benchmark payment designed to ensure adequate access to the service. In developing such benchmark the commissioner of health may utilize the average two thousand twenty Medicaid managed care payments for reimbursement of such private duty nursing services. The commissioner may promulgate regulations to implement the provisions of this paragraph.

3. Provider directory for fee-for-service private duty nursing services provided to medically fragile children and adults. The commissioner of health is authorized to establish a directory of qualified providers for the purpose of promoting the availability and ensuring delivery of fee-for-service private duty nursing services to medically fragile children [and individuals transitioning out of such category of care] and adults. Qualified providers enrolling in the directory shall ensure the availability and delivery of and shall provide such services to those individuals as are in need of such services, and shall receive increased reimbursement for such services pursuant to [paragraph (c)] paragraphs (c) and (d) of subdivision two of this section. The directory shall offer enrollment to all private duty nursing services providers to promote and ensure the participation in the directory of all nursing services providers available to serve medically fragile children and adults.

§ 2. Subdivision 3-a of section 3614 of the public health law, as amended by section 9 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

3-a. Medically fragile children and adults. Rates of payment for continuous nursing services for medically fragile children and adults provided by a certified home health agency, a licensed home care services agency or a long term home health care program shall be established to ensure the availability of such services, whether provided by registered nurses or licensed practical nurses who are employed by or under contract with such agencies or programs, and shall be established at a rate that is at least equal to rates of payment for such services rendered to patients eligible for AIDS home care programs; provided, however, that a certified home health agency, a licensed home care services agency or a long term home health care program that receives such enhanced rates for continuous nursing services for medically fragile children and adults shall use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide such services. In the case of services provided by certified home health agencies and long term home health care programs through contracts with licensed home care services agencies, rate increases received by such certified home health agencies and long term home health care programs pursuant to this subdivision shall be reflected in payments made to the registered nurses or licensed practical nurses employed by such licensed home care services agencies to render services to these children and adults. In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children and adults in a non-institutional setting as compared to an institutional setting. For the purposes of this subdivision, a medically fragile child shall mean a child who is at risk of hospitalization or institutionalization, including but not limited to children who are technologically-dependent for life or health-sustaining functions, require complex medication regimen or medical interventions to maintain or to improve their health status or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk, but who are capable of being cared for at home if provided with appropriate home care services, including but not limited to case management services and continuous nursing services. For the purposes of this subdivision, a medically fragile adult shall mean any individual who previously qualified as a medically fragile child but no longer meets the age requirement. The commissioner shall promulgate regulations to implement provisions of this subdivision and may also direct the providers specified in this subdivision to provide such additional information and in such form as the commissioner shall determine is reasonably necessary to implement the provisions of this subdivision.

§ 3. This act shall take effect immediately.

PART P

Intentionally Omitted

PART Q

Section 1. Section 268-c of the public health law is amended by adding a new subdivision 25 to read as follows:

25. The commissioner is authorized to submit the appropriate waiver applications to the United States secretary of health and human services

and/or the department of the treasury to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148 as amended, or successor provisions, as provided for by 42 U.S.C. 18052, and any other waivers necessary to achieve the purposes of high quality, affordable coverage through NY State of Health, the official health plan marketplace. The commissioner shall implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the secretary of health and human services and/or the secretary of the treasury pursuant to 42 U.S.C. 18052. Copies of such original waiver applications and amendments thereto shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee and the chairs of the senate and assembly health committees simultaneously with their submission to the federal government.

§ 2. Paragraph (d) of subdivision 3 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(d) (i) except as provided by subparagraph (ii) of this paragraph, has household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and [(ii)] has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; [however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to his or her immigration status.]

(ii) subject to federal approval and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, has household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size;

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible for and receiving coverage for health care services pursuant to this title is eligible to continue to receive health care services pursuant to this title during the pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this title;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs (2) or (4) of paragraph (b) of subdivision 1 of section three hundred and sixty-six of the social services law shall be deemed to have applied for medical assistance and to have been found eligible for such assistance

on the date of such birth and to remain eligible for such assistance for a period of one year.

An applicant who fails to make an applicable premium payment, if any, shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

§ 3. Paragraph (d) of subdivision 3 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(d) (i) except as provided by subparagraph (ii) of this paragraph, has household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and [(ii)] has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; [however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to his or her immigration status.]

(ii) subject to federal approval and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, has household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size;

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible for and receiving coverage for health care services pursuant to this title is eligible to continue to receive health care services pursuant to this title during the pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this title;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs (2) or (4) of paragraph (b) of subdivision 1 of section three hundred and sixty-six of the social services law shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

An applicant who fails to make an applicable premium payment shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

§ 4. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, [and] (ii) dental and vision services as defined by the commissioner, and (iii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

§ 5. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, and (ii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

§ 6. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, [and] (ii) dental and vision services as defined by the commissioner, and (iii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

§ 7. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of

financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, and (ii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

§ 7-a. Section 369-gg of the social services law is amended by adding a new subdivision 3-a to read as follows:

3-a. Alternate eligibility. A person shall be eligible to receive coverage for health care services under this title, without regard to federal financial participation, if he or she is a resident of New York state, has household income below two hundred fifty percent of the federal poverty line as defined and annually revised by the United States department of health and human services for a household of the same size, and is ineligible for federal financial participation in the basic health program under 42 USC section 18051 on the basis of immigration status, but otherwise meets the eligibility requirements in paragraphs (b) and (c) of subdivision three of this section. An applicant who fails to make an applicable premium payment shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

§ 7-b. Paragraph (b) of subdivision 5 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval. There shall be no cost-sharing obligations for enrollees for dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision one of this section; services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision one of this section; and health care services authorized under subparagraphs (iii) and (iv) of paragraph (d) of subdivision three of this section.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022, provided however:

(a) the amendments to paragraph (d) of subdivision 3 and paragraph (b) of subdivision 5 of section 369-gg of the social services law made by sections two and seven-b of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 3 of part H of chapter 57 of the laws of 2021 as amended, when upon such date the provisions of section three of this act shall take effect;

(b) section four of this act shall expire and be deemed repealed December 31, 2024; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section five of this act shall take effect; provided, however, the amendments to such paragraph made by section five of this act shall expire and be deemed repealed December 31, 2024; and

(c) section six of this act shall take effect January 1, 2025; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section seven of this act shall take effect.

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

PART R

Intentionally Omitted

PART S

Section 1. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (jj) to read as follows:

(jj) pre-natal and post-partum care and services for the purpose of improving maternal health outcomes and reduction of maternal mortality, when such services are recommended by a physician or other health care practitioner authorized under title eight of the education law, and provided by qualified practitioners. Such services shall include but not be limited to nutrition services provided by certified dietitians and certified nutritionists; care coordination, case management, and peer support; patient navigation services; services provided by licensed clinical social workers; dyadic services; Bluetooth-enabled devices for remote patient monitoring; and other services determined by the commissioner of health; provided, however, that the provisions of this paragraph shall not take effect unless there is federal financial participation. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

§ 2. Subparagraph 3 of paragraph (d) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(3) cooperates with the appropriate social services official or the department in establishing paternity or in establishing, modifying, or enforcing a support order with respect to his or her child; provided, however, that nothing herein contained shall be construed to require a payment under this title for care or services, the cost of which may be met in whole or in part by a third party; notwithstanding the foregoing, a social services official shall not require such cooperation if the social services official or the department determines that such actions would be detrimental to the best interest of the child, applicant, or recipient, or with respect to pregnant women during pregnancy and during the [sixty-day] one year period beginning on the last day of pregnancy, in accordance with procedures and criteria established by regulations of the department consistent with federal law; and

§ 3. Subparagraph 1 of paragraph (b) of subdivision 4 of section 366 of the social services law, as added by section 2 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) A pregnant woman eligible for medical assistance under subparagraph two or four of paragraph (b) of subdivision one of this section on any day of her pregnancy will continue to be eligible for such care and services [through the end of the month in which the sixtieth day following the end of the pregnancy occurs,] for a period of one year beginning on the last day of pregnancy, without regard to any change in the income of the family that includes the pregnant woman, even if such change otherwise would have rendered her ineligible for medical assistance.

§ 4. Section 369-hh of the social services law is REPEALED.

§ 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, that sections two, three and four of this act shall take effect March 1, 2023.

PART T

Intentionally Omitted

PART U

Section 1. Subdivision 7 of section 2510 of the public health law, as amended by chapter 436 of the laws of 2021, is amended to read as follows:

7. "Covered health care services" means: the services of physicians, optometrists, nurses, nurse practitioners, midwives and other related professional personnel which are provided on an outpatient basis, including routine well-child visits; diagnosis and treatment of illness and injury; inpatient health care services; laboratory tests; diagnostic x-rays; prescription and non-prescription drugs, ostomy and other medical supplies and durable medical equipment; radiation therapy; chemotherapy; hemodialysis; outpatient blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies; emergency room services; ambulance services; hospice services; emergency, preventive and routine dental care, including [medically necessary] orthodontia but excluding cosmetic surgery; emergency, preventive and routine vision care, including eyeglasses; speech and hearing services; [and,] inpatient and outpatient mental health, alcohol and substance abuse services, including children and family treatment and support services, children's home and community based services, assertive community treatment services and residential rehabilitation for youth services which shall be reimbursed in accordance with the ambulatory patient group (APG) rate-setting methodology under section twenty-eight hundred seven of this chapter; and health-related services provided by voluntary foster care agency health facilities licensed pursuant to article twenty-nine-I of this chapter; as defined by the commissioner [in consultation with the superintendent]. "Covered health care services" shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that any denial of coverage of such drugs, procedures or supplies shall provide the patient with the means of obtaining additional information concerning both the denial and the means of challenging such denial.

§ 2. Subdivision 9 of section 2510 of the public health law is amended by adding a new paragraph (e) to read as follows:

(e) for periods on or after October first, two thousand twenty-two, amounts as follows:

(i) no payments are required for eligible children whose family household income is less than two hundred twenty-three percent of the non-farm federal poverty level and for eligible children who are American Indians or Alaskan Natives, as defined by the United States department of health and human services, whose family household income is less than two hundred fifty-one percent of the non-farm federal poverty level; and

(ii) fifteen dollars per month for each eligible child whose family household income is between two hundred twenty-three percent and two hundred fifty percent of the non-farm federal poverty level, but no more than forty-five dollars per month per family; and

(iii) thirty dollars per month for each eligible child whose family household income is between two hundred fifty-one percent and three hundred percent of the non-farm federal poverty level, but no more than ninety dollars per month per family; and

(iv) forty-five dollars per month for each eligible child whose family household income is between three hundred one percent and three hundred fifty percent of the non-farm federal poverty level, but no more than one hundred thirty-five dollars per month per family; and

(v) sixty dollars per month for each eligible child whose family household income is between three hundred fifty-one percent and four hundred percent of the non-farm federal poverty level, but no more than one hundred eighty dollars per month per family.

§ 3. This act shall take effect immediately; provided, however, that section one of this act shall take effect January 1, 2023 and section two of this act shall take effect April 1, 2022.

PART V

Intentionally Omitted

PART W

Section 1. Section 365-g of the social services law, as added by chapter 938 of the laws of 1990, subdivisions 1 and 3 as amended by chapter 165 of the laws of 1991, subdivisions 2 and 4 as amended by section 31 of part C of chapter 58 of the laws of 2008, clause (B) of subparagraph (iii) of paragraph (b) of subdivision 3 as amended by chapter 59 of the laws of 1993, subparagraphs (vi) and (vii) of paragraph (b) of subdivision 3 as amended and subparagraph (viii) as added by section 31-b of part C of chapter 58 of the laws of 2008, subdivision 5 as amended by chapter 41 of the laws of 1992, paragraphs (f) and (g) of subdivision 5 as amended by and paragraphs (h) and (i) as added by section 31-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

§ 365-g. Utilization [thresholds] review for certain care, services and supplies. 1. The department may implement a system for utilization [controls] review, pursuant to this section, for persons eligible for benefits under this title, [including annual service limitations or utilization thresholds above which the department may not pay for additional care, services or supplies, unless such care, services or supplies have been previously approved by the department or unless such care, services or supplies were provided pursuant to subdivision three,

four or five of this section] to evaluate the appropriateness and quality of medical assistance, and safeguard against unnecessary utilization of care and services, which shall include a post-payment review process to develop and review beneficiary utilization profiles, provider service profiles, and exceptions criteria to correct misutilization practices of beneficiaries and providers; and for referral to the office of Medicaid inspector general where suspected fraud, waste or abuse are identified in the unnecessary or inappropriate use of care, services or supplies furnished under this title.

2. The department may [implement] review utilization [thresholds] by provider service type, medical procedure and patient, in consultation with the state department of mental hygiene, other appropriate state agencies, and other stakeholders including provider and consumer representatives. In [developing] reviewing utilization [thresholds], the department shall consider historical recipient utilization patterns, patient-specific diagnoses and burdens of illness, and the anticipated recipient needs in order to maintain good health.

3. If the department implements [a] utilization [threshold program] review, at a minimum, such [program must] review shall include:

(a) prior notice to the recipients affected by [the] utilization [threshold program] review, which the notice must describe: [(i)] the nature and extent of the utilization [program] review, [the procedures for obtaining an exemption from or increase in a utilization threshold,] the recipients' fair hearing rights, and referral to an informational toll-free hot-line operated by the department; and

[(ii) alternatives to the utilization threshold program such as enrollment in managed care programs and referral to preferred primary care providers designated pursuant to subdivision twelve of section twenty-eight hundred seven of the public health law; and]

(b) procedures for:

(i) requesting an increase in amount of authorized services;

(ii) extending amount of authorized services when an application for an increase in the amount of authorized services is pending;

(iii) requesting an exemption from utilization [thresholds] reviews, which the procedure must:

(A) allow the recipient, or a provider on behalf of a recipient, to apply to the department for an exemption from one or more utilization [thresholds] reviews based upon documentation of the medical necessity for services in excess of the threshold,

(B) provided for exemptions consistent with department guidelines for approving exemptions, which guidelines must be established by the department in consultation with the department of health and, as appropriate, with the department of mental hygiene, and consistent with the current regulations of the office of mental health governing outpatient treatment.

(C) provide for an exemption when medical and clinical documentation substantiates a condition of a chronic medical nature which requires ongoing and frequent use of medical care, services or supplies such that an increase in the amount of authorized services is not sufficient to meet the medical needs of the recipient;

[(iv) reimbursing a provider, regardless of the recipient's previous use of services, when care, services or supplies are provided in a case of urgent medical need, as defined by the department, or when provided on an emergency basis, as defined by the department;

(v) notifying recipients of and referring recipients to appropriate and accessible managed care programs and to preferred primary care

providers designated pursuant to subdivision twelve of section twenty-eight hundred seven of the public health law at the same time such recipients are notified that they are nearing or have reached the utilization threshold for each specific provider type;

(vi) notifying recipients at the same time such recipients are notified that they have received an exemption from a utilization threshold, an increase in the amount of authorized services, or that they are nearing or have reached their utilization threshold, of their possible eligibility for federal disability benefits and directing such recipients to their social services district for information and assistance in securing such benefits;

(vii) cooperating with social services districts in sharing information collected and developed by the department regarding recipients' medical records; and

(viii)] (iv) assuring that no request for an increase in amount of authorized services or for an exemption from utilization [thresholds] reviews shall be denied unless the request is first reviewed by a health care professional possessing appropriate clinical expertise.

4. The utilization [thresholds] review established pursuant to this section shall not apply to [mental retardation and] developmental disabilities services provided in clinics certified under article twenty-eight of the public health law, or article twenty-two or article thirty-one of the mental hygiene law.

5. Utilization [thresholds] review established pursuant to this section shall not apply to services, even though such services might otherwise be subject to utilization [thresholds] review, when provided as follows:

(a) through a managed care program;

(b) subject to prior approval or prior authorization;

(c) as family planning services;

(d) as methadone maintenance services;

(e) on a fee-for-services basis to in-patients in general hospitals certified under article twenty-eight of the public health law or article thirty-one of the mental hygiene law and residential health care facilities, with the exception of podiatrists' services;

(f) for hemodialysis;

(g) through or by referral from a preferred primary care provider designated pursuant to subdivision twelve of section twenty-eight hundred seven of the public health law;

(h) pursuant to a court order; or

(i) as a condition of eligibility for any other public program, including but not limited to public assistance.

6. The department shall consult with representatives of medical assistance providers, social services districts, voluntary organizations that represent or advocate on behalf of recipients, the managed care advisory council and other state agencies regarding the ongoing operation of a utilization [threshold] review system.

7. On or before February first, nineteen hundred ninety-two, the commissioner shall submit to the governor, the temporary president of the senate and the speaker of the assembly a report detailing the implementation of the utilization threshold program and evaluating the results of establishing utilization thresholds. Such report shall include, but need not be limited to, a description of the program as implemented; the number of requests for increases in service above the threshold amounts by provider and type of service; the number of extensions granted; the number of claims that were submitted for emergency

care or urgent care above the threshold level; the number of recipients referred to managed care; an estimate of the fiscal savings to the medical assistance program as a result of the program; recommendations for medical condition that may be more appropriately served through managed care programs; and the costs of implementing the program.

§ 2. This act shall take effect July 1, 2022; provided, however, that:

a. the amendments to subdivision 5 of section 365-g of the social services law made by section one of this act shall not affect the expiration and reversion of paragraphs (f) and (g) of such subdivision pursuant to subdivision (i-1) of section 79 of part C of chapter 58 of the laws of 2008, as amended; and

b. the amendments to subdivision 5 of section 365-g of the social services law made by section one of this act shall not affect the repeal of paragraphs (h) and (i) of such subdivision pursuant to subdivision (i-1) of section 79 of part C of chapter 58 of the laws of 2008, as amended.

PART X

Intentionally Omitted

PART Y

Intentionally Omitted

PART Z

Section 1. Intentionally Omitted.

§ 2. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,

between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [and] between July 1, 2021 and June 30, 2022, and between July 1, 2022 and June 30, 2023 or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [and] between July 1, 2021 and June 30, 2022, and between July 1, 2022 and June 30, 2023 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred

thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 3. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [and] between July 1, 2021 and June 30, 2022<u>, and between July 1, 2022 and June 30, 2023</u> allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June

30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [and] between July 1, 2021 and June 30, 2022<u>, and between July 1, 2022 and June 30, 2023</u> allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, to the period July 1, 2016 and

June 30, 2017, to the period July 1, 2017 to June 30, 2018, to the period July 1, 2018 to June 30, 2019, to the period July 1, 2019 to June 30, 2020, to the period July 1, 2020 to June 30, 2021, [and] to the period July 1, 2021 to June 30, 2022, and to the period July 1, 2022 to June 30, 2023.

§ 4. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part K of chapter 57 of the laws of 2021, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, during the period July 1, 2018 to June 30, 2019, during the period July 1, 2019 to June 30, 2020, during the period July 1, 2020 to June 30, 2021, [and] during the period July 1, 2021 to June 30, 2022, and during the period July 1, 2022 to June 30, 2023 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period

April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023 determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accord-

ance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022<u>, or covering the period July 1, 2022 to June 1, 2023</u> that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and

to the period July 1, 2017 to June 30, 2018, and to the period July 1, 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020, and to the period July 1, 2020 to June 30, 2021, and to the period July 1, 2021 to June 30, 2022, and to the period July 1, 2022 to June 30, 2023 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018, and covering the period July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to June 30, 2020, and covering the period July 1, 2020 to June 30, 2021, and covering the period July 1, 2021 to June 30, 2022, and covering the period July 1, 2022 to June 30, 2023 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 5. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 4 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [2022] 2023; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [2022] 2023, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient

to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [2022] 2023 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 6. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part K of chapter 57 of the laws of 2021, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, [and] June 15, 2022, and June 15, 2023 the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of

the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023 as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023 as applicable.

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of financial services for the purchase of excess liability insurance coverage for eligible participating physicians and dentists for the policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, as applicable, and the cost of administering the hospital excess liability pool for such applicable policy year, pursuant to the program established in chapter 266 of the laws of 1986, as amended, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, [and] June 15, 2022, and June 15, 2023 as applicable.

§ 7. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

§ 20. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand [twenty-one] twenty-two, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [twenty-one] twenty-two; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand [twenty-one] twenty-two exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [twenty-one] twenty-two, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand [twenty-one] twenty-two, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [twenty-one] twenty-two and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [twenty-one] twenty-two.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART AA

Intentionally Omitted

PART BB

Intentionally Omitted

PART CC

Section 1. Paragraph (m) of subdivision 3 of section 461-l of the social services law, as added by section 2 of part B of chapter 57 of the laws of 2018, is amended to read as follows:

(m) Beginning April first, two thousand [twenty-three] twenty-five, additional assisted living program beds shall be approved on a case by case basis whenever the commissioner of health is satisfied that public need exists at the time and place and under circumstances proposed by the applicant.

(i) The consideration of public need may take into account factors such as, but not limited to, regional occupancy rates for adult care facilities and assisted living program occupancy rates and the extent to which the project will serve individuals receiving medical assistance.

(ii) Existing assisted living program providers may apply for approval to add up to nine additional assisted living program beds that do not require major renovation or construction under an expedited review proc-

ess. The expedited review process is available to applicants that are in good standing with the department of health, and are in compliance with appropriate state and local requirements as determined by the department of health. The expedited review process shall allow certification of the additional beds for which the commissioner of health is satisfied that public need exists within ninety days of such department's receipt of a satisfactory application.

§ 2. Subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, as amended by section 6 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(f) section twenty-five of this act shall expire and be deemed repealed April 1, [2022] 2025;

§ 3. Subdivision (c) of section 122 of part E of chapter 56 of the laws of 2013 amending the public health law relating to the general public health work program, as amended by section 7 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(c) section fifty of this act shall take effect immediately and shall expire [nine years after it becomes law] and be deemed repealed April 1, 2031;

§ 4. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 22 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, and for the state fiscal year beginning April 1, 2016 through March 31, 2019, and for the state fiscal year beginning April 1, 2019 through March 31, 2022, and for the state fiscal year beginning April 1, 2022 through March 31, 2025, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assist-

ance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

§ 5. Section 5 of chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, as amended by section 20 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 5. This act shall take effect on the one hundred twentieth day after it shall have become a law, provided, however, that the provisions of sections two, three, and four of this act shall expire and be deemed repealed July 1, [2022] <u>2024</u>; provided, however, that the amendments to subdivision 1 of section 6801 of the education law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 8 of chapter 563 of the laws of 2008, when upon such date the provisions of section one-a of this act shall take effect; provided, further, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

§ 6. Section 2 of part II of chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, as amended by section 1 of item C of subpart H of part XXX of chapter 58 of the laws of 2020, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [2022] 2024.

§ 7. Intentionally omitted.

§ 8. Paragraph (c) of subdivision 6 of section 958 of the executive law, as added by chapter 337 of the laws of 2018, is amended to read as follows:

(c) prepare and issue a report on the working group's findings and recommendations by May first, two thousand [nineteen] twenty-three to the governor, the temporary president of the senate and the speaker of the assembly.

§ 9. Subdivision 2 of section 207-a of the public health law, as added by chapter 364 of the laws of 2018, is amended to read as follows:

2. Such report shall be submitted to the temporary president of the senate and the speaker of the assembly no later than October first, two thousand [nineteen] twenty-two. The department and the commissioner of mental health may engage stakeholders in the compilation of the report, including but not limited to, medical research institutions, health care practitioners, mental health providers, county and local government, and advocates.

§ 10. Sections 2 and 3 of chapter 74 of the laws of 2020 relating to directing the department of health to convene a work group on rare diseases, as amended by chapter 199 of the laws of 2021, are amended to read as follows:

§ 2. The department of health, in collaboration with the department of financial services, shall convene a workgroup of individuals with expertise in rare diseases, including physicians, nurses and other health care professionals with experience researching, diagnosing or treating rare diseases; members of the scientific community engaged in rare disease research; representatives from the health insurance industry; individuals who have a rare disease or caregivers of a person with a rare disease; and representatives of rare disease patient organizations. The workgroup's focus shall include, but not be limited to: identifying best practices that could improve the awareness of rare diseases and referral of people with potential rare diseases to specialists and evaluating barriers to treatment, including financial barriers on access to care. The department of health shall prepare a written report summarizing opinions and recommendations from the workgroup which includes a list of existing, publicly accessible resources on research, diagnosis, treatment, coverage options and education relating to rare diseases. The workgroup shall convene no later than December twentieth, two thousand twenty-one and this report shall be submitted to the governor, speaker of the assembly and temporary president of the senate no later than [three] four years following the effective date of this act and shall be posted on the department of health's website.

§ 3. This act shall take effect on the same date and in the same manner as a chapter of the laws of 2019, amending the public health law relating to establishing the rare disease advisory council, as proposed in legislative bills numbers S. 4497 and A. 5762; provided, however, that the provisions of section two of this act shall expire and be deemed repealed [three] four years after such effective date.

§ 11. Sections 5 and 6 of chapter 414 of the laws of 2018, creating the radon task force, as amended by section 1 of item M of subpart B of part XXX of chapter 58 of the laws of 2020, are amended to read as follows:

§ 5. A report of the findings and recommendations of the task force and any proposed legislation necessary to implement such findings shall

be filed with the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate, and the minority leader of the assembly on or before November first, two thousand [twenty-one] twenty-two.

§ 6. This act shall take effect immediately and shall expire and be deemed repealed December 31, [2021] 2022.

§ 12. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, that section eleven of this act shall be deemed to have been in full force and effect on and after December 31, 2021; and provided, further, that the amendments to section 2 of chapter 74 of the laws of 2020 made by section ten of this act and the amendments to section 5 of chapter 414 of the laws of 2018 made by section eleven of this act, shall not affect the repeal of such sections and be deemed repealed therewith.

PART DD

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners of the department of health, office of mental health, office for people with developmental disabilities, office of addiction services and supports, office of temporary and disability assistance, office of children and family services, and the state office for the aging shall establish a cost of living adjustment (COLA), effective April 1, 2022, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in paragraphs (i), (ii), (iii), (iv), (v), (vi), and (vii) of subdivision six of this section. The COLA established herein shall be applied to the appropriate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the department of health (DOH) shall be made as reimbursement for the state share of medical assistance.

2. In developing cost of living adjustments under this section, the commissioners shall use the most recent congressional budget office estimate of the budget year's U.S. consumer price index for all urban consumers published in the congressional budget office economic and budget outlook after June first of the budget year prior to the year for which rates of payments, contracts or any other form of reimbursement are being developed.

3. After final U.S. consumer price index (CPI) for all urban consumers published by the United States department of labor, bureau of labor statistics, for a particular budget year, the commissioners shall reconcile such final CPI with the estimate used in subdivision two of this section and any difference will be included in the next prospective cost of living adjustment.

4. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefore, for the period of April 1, 2022 through March 31, 2023, the commissioners shall provide funding to support an eleven percent (11%) cost of living adjustment under this section for all eligible programs and services as determined pursuant to subdivision six of this section.

5. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 11 percent cost of living adjustment (COLA) established herein shall be inclusive of all other cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2022. Except for the 11 percent cost of

living adjustment (COLA) established herein, for the period commencing on April 1, 2022 the commissioners shall not apply any other new cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other cost of living type increases, inflation factors, or trend factors" as defined in this subdivision shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic Public Health Emergency.

6. Eligible programs and services. (i) Programs and services funded, licensed, or certified by the office of mental health (OMH) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: office of mental health licensed outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of the office of mental health regulations including clinic, continuing day treatment, day treatment, intensive outpatient programs and partial hospitalization; outreach; crisis residence; crisis stabilization, crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric emergency program services; crisis intervention; home based crisis intervention; family care; supported single room occupancy; supported housing; supported housing community services; treatment congregate; supported congregate; community residence - children and youth; treatment/apartment; supported apartment; community residence single room occupancy; on-site rehabilitation; employment programs; recreation; respite care; transportation; psychosocial club; assertive community treatment; case management; care coordination, including health home plus services; local government unit administration; monitoring and evaluation; children and youth vocational services; single point of access; school-based mental health program; family support children and youth; advocacy/support services; drop in centers; recovery centers; transition management services; bridger; home and community based waiver services; behavioral health waiver services authorized pursuant to the section 1115 MRT waiver; self-help programs; consumer service dollars; conference of local mental hygiene directors; multicultural initiative; ongoing integrated supported employment services; supported education; mentally ill/chemical abuse (MICA) network; personalized recovery oriented services; children and family treatment and support services; residential treatment facilities operating pursuant to part 584 of title 14-NYCRR; geriatric demonstration programs; community-based mental health family treatment and support; coordinated children's service initiative; homeless services; and promises zone.

(ii) Programs and services funded, licensed, or certified by the office for people with developmental disabilities (OPWDD) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: local/unified services; chapter 620 services; voluntary operated community residential services; article 16 clinics; day treatment services; family support services; 100% day training; epilepsy services; traumatic brain injury services; hepatitis B services; independent practitioner services for individuals with intellectual and/or developmental disabilities; crisis services for individuals with intellectual and/or developmental disabilities; family care residential habilitation; supervised residential habilitation; supportive residential habilitation; respite; day habilitation; prevocational services; supported employment; community habilitation; intermediate care facility day and residential services; specialty hospital; pathways to employment; intensive behavioral services; basic home and

community based services (HCBS) plan support; health home services provided by care coordination organizations; community transition services; family education and training; fiscal intermediary; support broker; and personal resource accounts.

(iii) Programs and services funded, licensed, or certified by the office of addiction services and supports (OASAS) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: medically supervised withdrawal services - residential; medically supervised withdrawal services - outpatient; medically managed detoxification; medically monitored withdrawal; inpatient rehabilitation services; outpatient opioid treatment; residential opioid treatment; KEEP units outpatient; residential opioid treatment to abstinence; problem gambling treatment; medically supervised outpatient; outpatient rehabilitation; specialized services substance abuse programs; home and community based waiver services pursuant to subdivision 9 of section 366 of the social services law; children and family treatment and support services; continuum of care rental assistance case management; NY/NY III post-treatment housing; NY/NY III housing for persons at risk for homelessness; permanent supported housing; youth clubhouse; recovery community centers; recovery community organizing initiative; residential rehabilitation services for youth (RRSY); intensive residential; community residential; supportive living; residential services; job placement initiative; case management; family support navigator; local government unit administration; peer engagement; vocational rehabilitation; support services; HIV early intervention services; dual diagnosis coordinator; problem gambling resource centers; problem gambling prevention; prevention resource centers; primary prevention services; other prevention services; and community services.

(iv) Programs and services funded, licensed, or certified by the office of temporary and disability assistance (OTDA) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: nutrition outreach and education program (NOEP) and the New York state supportive housing program (NYSSHP).

(v) Programs and services funded, licensed, or certified by the office of children and family services (OCFS) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: programs for which the office of children and family services establishes maximum state aid rates pursuant to section 398-a of the social services law and section 4003 of the education law; emergency foster homes; foster family boarding homes and therapeutic foster homes as defined by the regulations of the office of children and family services; supervised settings as defined by subdivision twenty-two of section 371 of the social services law; adoptive parents receiving adoption subsidy pursuant to section 453 of the social services law; congregate and scattered supportive housing programs and supportive services provided under the NY/NY III supportive housing agreement to young adults leaving or having recently left foster care; and preventive services as defined pursuant to section 409 of the social services law.

(vi) Programs and services funded, licensed, or certified by the state office for the aging (SOFA) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: community services for the elderly; expanded in-home services for the elderly; and supplemental nutrition assistance program.

(vii) Programs and services funded, licensed, or certified by the state department of health (DOH) eligible for the cost of living adjustment established herein, pending federal approval where applicable,

shall include the health home care management program as authorized by section 365-l of the social services law.

7. Each local government unit or direct contract provider receiving funding for the cost of living adjustment established herein shall submit a written certification, in such form and at such time as each commissioner shall prescribe, attesting how such funding will be or was used to first promote the recruitment and retention of non-executive direct care staff, non-executive direct support professionals, non-executive clinical staff, or respond to other critical non-personal service costs prior to supporting any salary increases or other compensation for executive level job titles.

8. Notwithstanding any inconsistent provision of law to the contrary, agency commissioners shall be authorized to recoup funding from a local governmental unit or direct contract provider for the cost of living adjustment established herein determined to have been used in a manner inconsistent with the appropriation, or any other provision of this section. Such agency commissioners shall be authorized to employ any legal mechanism to recoup such funds, including an offset of other funds that are owed to such local governmental unit or direct contract provider.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022.

PART EE

Section 1. Short title. This act shall be known and may be cited as the "9-8-8 suicide prevention and behavioral health crisis hotline act".

§ 2. The mental hygiene law is amended by adding a new section 36.03 to read as follows:

§ 36.03 9-8-8 suicide prevention and behavioral health crisis hotline system.

(a) Definitions. When used in this article, the following words and phrases shall have the following meanings unless the specific context clearly indicates otherwise:

(1) "9-8-8" means the three digit phone number designated by the federal communications commission for the purpose of connecting individuals experiencing a behavioral health crisis with suicide prevention and behavioral health crisis counselors, mobile crisis teams, and crisis stabilization services and other behavioral health crises services through the national suicide prevention lifeline.

(2) "9-8-8 crisis hotline center" means a state-identified and funded center participating in the National Suicide Prevention Lifeline Network to respond to statewide or regional 9-8-8 calls.

(3) "Crisis stabilization centers" means facilities providing short-term observation and crisis stabilization services jointly licensed by the office of mental health and the office of addiction services and supports under section 36.01 of this article.

(4) "Crisis residential services" means a short-term residential program designed to provide residential and support services to persons with symptoms of mental illness who are at risk of or experiencing a psychiatric crisis.

(5) "Crisis intervention services" means the continuum to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery oriented. Crisis intervention services include but not limited to: crisis stabilization centers, mobile crisis teams, and crisis residential services.

(6) "Behavioral health professional" shall mean any of the following, but shall not be limited to:

(i) a licensed clinical social worker, licensed under article one hundred fifty-four of the education law;

(ii) a licensed psychologist, licensed under article one hundred fifty-three of the education law;

(iii) a registered professional nurse, licensed under article one hundred thirty-nine of the education law;

(iv) a licensed master social worker, licensed under article one hundred fifty-four of the education law, under the supervision of a physician, psychologist or licensed clinical social worker;

(v) a licensed mental health counselor, licensed under article one hundred sixty-three of the education law; or

(vi) a credentialed alcoholism and substance use counselor with a valid credential issued or approved by the office.

(7) "Peer" shall mean an individual who is a current or former recipient of mental health or substance use services who provides advocacy and mutual support for other services users through a model of shared personal experience, who is employed on the basis of their personal knowledge and recovery from a mental illness, addiction, or both, and who meets the certification requirements set forth by the New York state peer specialist certification board.

(8) "Family peer advocates" shall mean individuals with lived experience as the biological, foster, or adoptive parents or primary caregivers of a child or youth with a social, emotional, behavioral, mental health, substance use disorder, or developmental disability, who meet the current requirements for a credentialed family peer advocate, or other certification related to culturally responsive trauma-informed care.

(9) "Mobile crisis team" means a team licensed, certified, or authorized by the office of mental health and the office of addiction services and supports to provide community-based mental health or substance use disorder interventions for individuals who are experiencing a mental health or substance use disorder crisis. Members of a mobile crisis team may include, but not be limited to: behavioral health professionals family peer advocates, and peers.

(10) "National suicide prevention lifeline" or "NSPL" means the national network of local crisis centers that provide free and confidential emotional support to people in suicidal crisis or emotional distress twenty-four hours a day, seven days a week via a toll-free hotline number, which receives calls made through the 9-8-8 system. The toll-free number is maintained by the Assistant Secretary for Mental Health and Substance Use under Section 50-E-3 of the Public Health Service Act, Section 290bb-36c of Title 42 of the United States Code.

(b) The commissioner of the office of mental health, in conjunction with the commissioner of the office of addiction services and supports, shall have joint oversight of the 9-8-8 suicide prevention and behavioral health crisis hotline and shall work in concert with NSPL for the purposes of ensuring consistency of public messaging.

(c) The commissioner of the office of mental health, in conjunction with the commissioner of the office of addiction services and supports, shall, on or before July sixteenth, two thousand twenty-two, designate a crisis hotline center or centers to provide or arrange for crisis intervention services to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline from anywhere within the state

twenty-four hours a day, seven days a week. Each 9-8-8 crisis hotline center shall do all of the following:

(1) A designated hotline center shall have an active agreement with the administrator of the National Suicide Prevention Lifeline for participation within the network.

(2) A designated hotline center shall meet NSPL requirements and best practices guidelines for operation and clinical standards.

(3) A designated hotline center may utilize technology, including but not limited to, chat and text that is interoperable between and across the 9-8-8 suicide prevention and behavioral health crisis hotline system and the administrator of the National Suicide Prevention Lifeline.

(4) A designated hotline center shall accept transfers of any call from 9-1-1 pertaining to a behavioral health crisis.

(5) A designated hotline center shall ensure coordination between the 9-8-8 crisis hotline centers, 9-1-1, behavioral health crisis services, and, when appropriate, other specialty behavioral health warm lines and hotlines and other emergency services. If a law enforcement, medical, or fire response is also needed, 9-8-8 and 9-1-1 operators shall coordinate the simultaneous deployment of those services with mobile crisis services.

(6) A designated hotline center shall have the authority to deploy crisis intervention services, including but not limited to mobile crisis teams, and coordinate access to crisis stabilization centers, and other behavioral health crisis intervention services, as appropriate, and according to guidelines and best practices established by New York State and the NSPL.

(7) A designated hotline center shall meet the requirements set forth by New York State and the NSPL for serving high risk and specialized populations including but not limited to: Black, African American, Hispanic, Latino, Asian, Pacific Islander, Native American, Alaskan Native; lesbian, gay, bisexual, transgender, nonbinary, queer, and questioning individuals; veterans; members of rural communities; individuals with intellectual and developmental disabilities; individuals experiencing homelessness or housing instability; immigrants and refugees; children and youth; older adults; and religious communities as identified by the federal Substance Abuse and Mental Health Services Administration, including training requirements and policies for providing linguistically and culturally competent care.

(8) A designated hotline center shall provide follow-up services as needed to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline consistent with guidance and policies established by New York State and the NSPL. Follow-up services guidelines and policies shall include but not be limited to: (i) criteria for enrollment in a designated hotline center follow-up program, including consideration of a caller's suicide risk, staff resources, the crisis center's capacity to follow up with a caller, an individual's consent to participate in such follow-up program, and any relevant state or federal confidentiality provisions; (ii) linkage to services as needed; and (iii) the maximum duration of involvement that is appropriate with the follow-up program depending on an individual's potential risk level.

(9) A designated hotline center shall provide data, and reports, and participate in evaluations and quality improvement activities as required by the office of mental health and the office of addiction services and supports.

(d) The commissioner of the office of mental health, in conjunction with the commissioner of the office of addiction services and supports,

shall establish a comprehensive list of reporting metrics regarding the 9-8-8 suicide prevention and behavioral health crisis hotline's usage, services and impact which shall include, at a minimum:

(1) The volume of requests for assistance that the 9-8-8 suicide prevention and behavioral health crisis hotline received;

(2) The average length of time taken to respond to each request for assistance, and the aggregate rates of call abandonment;

(3) The types of requests for assistance that the 9-8-8 suicide prevention and behavioral health crisis hotline received; and

(4) The number of mobile crisis teams dispatched.

(e) The commissioner of the office of mental health, in conjunction with the commissioner of the office of addiction services and supports, shall submit an annual report on or by December thirty-first, two thousand twenty-three and annually thereafter, regarding the comprehensive list of reporting metrics to the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate and the minority leader of the assembly.

(f) Moneys allocated for the payment of costs determined in consultation with the commissioners of mental health and the office of addiction services and supports associated with the administration, design, installation, construction, operation, or maintenance of a 9-8-8 suicide prevention and behavioral health crisis hotline system serving the state, including, but not limited to: staffing, hardware, software, consultants, financing and other administrative costs to operate crisis call-centers throughout the state and the provision of acute and crisis intervention services for mental health and substance use disorder by directly responding to the 9-8-8 hotline established pursuant to the National Suicide Hotline Designation Act of 2020 (47 U.S.C. § 251a) and rules adopted by the Federal Communications Commission, including such costs incurred by the state, shall not supplant any separate existing, future appropriations, or future funding sources dedicated to the 9-8-8 crisis response system.

§ 3. This act shall take effect immediately.

PART FF

Section 1. Subdivision 5 of section 365-m of the social services law, as added by section 11 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

5. Pursuant to appropriations within the offices of mental health or addiction services and supports, the department of health shall reinvest [funds allocated for behavioral health services, which are general fund savings directly related to] savings realized through the transition of populations covered by this section from the applicable Medicaid fee-for-service system to a managed care model, including savings [resulting from the reduction of inpatient and outpatient behavioral health services provided under the Medicaid programs licensed or certified pursuant to article thirty-one or thirty-two of the mental hygiene law, or programs that are licensed pursuant to both article thirty-one of the mental hygiene law and article twenty-eight of the public health law, or certified under both article thirty-two of the mental hygiene law and article twenty-eight of the public health law] realized through the recovery of premiums from managed care providers which represent a reduction of spending on qualifying behavioral health services against established premium targets for behavioral health services and the medical loss ratio applicable to special needs managed care plans, for

the purpose of increasing investment in community based behavioral health services, including residential services certified by the office of [alcoholism and substance abuse] addiction services and supports. The methodologies used to calculate the savings shall be developed by the commissioner of health and the director of the budget in consultation with the commissioners of the office of mental health and the office of [alcoholism and substance abuse] addiction services and supports. In no event shall the full annual value of the [community based behavioral health service] reinvestment [savings attributable to the transition to managed care] pursuant to this subdivision exceed the [twelve month value of the department of health general fund reductions resulting from such transition] value of the premiums recovered from managed care providers which represent a reduction of spending on qualifying behavioral health services. Within any fiscal year where appropriation increases are recommended for reinvestment, insofar as managed care transition savings do not occur as estimated, [and general fund savings do not result,] then spending for such reinvestment may be reduced in the next year's annual budget itemization. [The commissioner of health shall promulgate regulations, and prior to October first, two thousand fifteen, may promulgate emergency regulations as required to distribute funds pursuant to this subdivision; provided, however, that any emergency regulations promulgated pursuant to this section shall expire no later than December thirty-first, two thousand fifteen.] The commissioner shall include detailed descriptions of the methodology used to calculate savings, information regarding the funds available for reinvestment, the results of applying such methodologies, the details regarding implementation of such reinvestment pursuant to this section[, and any regulations promulgated under this subdivision,] in the annual report required under section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen. Beginning April first, two thousand twenty-two, the department shall also post on its website the list of managed care providers that provided a recovery of premiums under this section, a detailed accounting of the amount that was recovered from each provider, and the dates that the recovery was applied to, beginning with recoveries from two thousand thirteen. After the initial posting of this information on its website, the department shall update it on an annual basis by December thirty-first each year.

§ 2. This act shall take effect immediately.

PART GG

Intentionally Omitted

PART HH

Intentionally Omitted

PART II

Section 1. Subdivision 38 of section 1.03 of the mental hygiene law, as amended by chapter 281 of the laws of 2019, is amended and a new subdivision 59 is added to read as follows:

38. "Residential services facility" or "Alcoholism community residence" means any facility licensed or operated pursuant to article thir-

ty-two of this chapter which provides residential services for the treatment of an addiction disorder and a homelike environment, including room, board and responsible supervision as part of an overall service delivery system. Provided however, "recovery living residence" as defined in subdivision fifty-nine of this section shall not be considered a residential services facility for the purposes of this chapter.

59. "Recovery living residence" means any shared residence in the state that has been certified by the office of addiction services and supports and meets criteria established pursuant to section 32.05-a of this chapter, where the owner or operator provides a supportive living arrangement for individuals recovering from a substance use disorder.

§ 2. The mental hygiene law is amended by adding a new section 32.05-a to read as follows:

§ 32.05-a Certification of recovery living residences.

1. No person or entity may purport to operate a recovery living residence except upon compliance with the regulations promulgated pursuant to this section. Any person or entity shall be considered purporting to operate a recovery living residence, regardless of whether such person or entity is offering onsite recovery services, so long as such person or entity holds itself out as a place where an individual reasonably believes such person or entity is providing recovery services and/or a sober environment.

2. The commissioner shall promulgate regulations consistent with this section for the purpose of certifying recovery living residences. Recovery living residences shall provide a supportive home like living environment for individuals recovering from a substance use disorder.

3. Such regulations shall be evidence-based, utilizing information from sources with expertise in treatment and recovery, with a focus on appropriate settings and activities most suited toward the recovery of the individual. Such regulations shall, at minimum, provide for:

(a) access to a certified alcohol and substance abuse counselor either onsite or via telehealth services;

(b) appropriate responses to individuals who relapse, which take into consideration the need for the individual to continue their recovery process at the residence as well as the impact on other residents;

(c) access to a licensed professional whose scope of practice includes the diagnosis of mental health disorders either onsite or via telehealth services for those recovering from a co-occurring mental health disorder;

(d) informing individuals of their rights while residing at the residence, which shall include but not be limited to rights related to privacy and confidentiality as provided by state and federal law, rights related to potential eviction from the recovery living residence and general rights and procedures related to individuals while residing in the recovery living residence; and

(e) operating procedures, which shall include administrative operations as well as ensuring residents are receiving other necessary health care services.

4. (a) The commissioner may certify recovery living residences that: (i) complete an application for such certification; (ii) are in compliance with the regulations established pursuant to subdivision two of this section; (iii) have demonstrated a need for a recovery living residence in the particular location identified by the applicant; (iv) can provide evidence or demonstrate their ability to effectively deliver an appropriate environment for individuals recovering from a substance use

disorder; and (v) meet or exceed the housing quality standards for safe and habitual housing which are established by local housing codes.

(b) As part of the application process, the applicant shall be required to demonstrate the outreach such applicant conducted in the community, including input provided by the community, concerns raised by the community and steps such applicant has taken or will take to potentially remediate some of those concerns.

5. Once the commissioner has certified a location as a recovery living residence, such residence shall be included on the office's website as an available option for individuals seeking such an environment.

6. The commissioner shall regulate and ensure residences who are certified to be a recovery living residence are continuing to meet the requirements of this section. The commissioner has the authority to inspect such residences and impose penalties, including limiting, revoking or suspending a certification, as appropriate, for failure to comply with the provisions of this section.

7. Currently operating non-certified residences shall have up to sixty days following the effective date of this section to ensure compliance with the regulations established pursuant to subdivision two of this section.

§ 3. Subdivisions 1, 2, 3, 5 and 6 of section 32.06 of the mental hygiene law, as added by chapter 223 of the laws of 2018, are amended to read as follows:

1. For purposes of this section, unless the context clearly requires otherwise, "provider" shall mean any person, firm, partnership, group, practice association, fiduciary, employer, representative thereof or any other entity who is providing or purporting to provide substance use disorder services or operating or purporting to operate a recovery living residence. Provided, however, that "provider" shall not include a person receiving substance use disorder services from the provider.

2. No provider shall intentionally solicit, receive, accept or agree to receive or accept any payment, benefit or other consideration in any form to the extent such payment, benefit or other consideration is given for the referral of a person as a potential patient for substance use disorder services or as a resident at a recovery living residence.

3. No provider providing or purporting to provide substance use disorder services or operating or purporting to operate a recovery living residence pursuant to this chapter, shall intentionally make, offer, give, or agree to make, offer, or give any payment, benefit or other consideration in any form to the extent such payment, benefit or other consideration is given for the referral of a person as a potential patient for substance use disorder services.

5. Any provider who intentionally violates the provisions of subdivision two or three of this section shall be guilty of a misdemeanor as defined in the penal law. Additionally, any entity purporting to operate a recovery living residence without receiving a certification from the office shall, upon reasonable notice of non-compliance, be guilty of a misdemeanor as defined in the penal law; provided, however, this provision shall not apply to currently operating non-certified residences who are taking steps to come into compliance with section 32.05-a of this article and have submitted an application to the office and are awaiting certification from the commissioner.

6. If the commissioner has reason to believe a provider has violated subdivision two or three of this section, the commissioner may proceed to investigate and institute enforcement actions, as may be authorized pursuant to the applicable provisions of this article. Additionally, if

the commissioner has reason to believe an entity is operating a recovery living residence without receiving a certification from the office or purporting to operate a recovery living residence, the commissioner may proceed to investigate and institute enforcement actions, as may be authorized pursuant to the applicable provisions of this article.

§ 4. This act shall take effect on the sixtieth day after it shall have become a law.

PART JJ

Section 1. The section heading and subdivisions (a) and (d) of section 19.25 of the mental hygiene law, as added by chapter 223 of the laws of 1992, are amended to read as follows:

[Alcohol] Substance use awareness program.

(a) The office shall establish [an alcohol] a substance use awareness program within the office which shall focus upon, but not be limited to, the health effects and social costs of [alcoholism and alcohol abuse] substance use disorders.

(d) [A] Upon completion, a certificate of completion shall be sent to the court by the [office upon completion of the program by all] program for participants who have been ordered by the court to complete such program.

§ 2. This act shall take effect immediately.

PART KK

Intentionally Omitted

PART LL

Section 1. Section 48-a of part A of chapter 56 of the laws of 2013 amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 18 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of [alcoholism and substance abuse] addiction services and supports and the office of mental health are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 36, 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of the office of mental health, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of

[alcoholism and substance abuse] addiction services and supports, or the office of mental health for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [1] 18 of part [P] E of chapter 57 of the laws of [2017] 2019 through March 31, [2023] 2027 for patients in the city of New York, for all rate periods on and after the effective date of section [1] 18 of part [P] E of chapter 57 of the laws of [2017] 2019 through March 31, [2023] 2027 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through March 31, [2023] 2027 for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [alcoholism and substance abuse] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

2. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 36,

31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology or any such other fees established pursuant to the Medicaid state plan. The commissioner of health shall consult with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through March 31, [2023] 2027, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [alcoholism and substance abuse] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

§ 2. Section 1 of part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, as amended by section 19 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and [alcoholism and substance abuse] addiction services and supports are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 36, 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of [alcoholism and substance abuse] addiction services and supports, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of [alcoholism and substance abuse] addiction services and supports for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commission-

ers of mental health and [alcoholism and substance abuse] addiction services and supports, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [2] 19 of part [P] E of chapter 57 of the laws of [2017] 2019 through March 31, [2023] 2027 for patients in the city of New York, for all rate periods on and after the effective date of section [2] 19 of part [P] E of chapter 57 of the laws of [2017] 2019 through March 31, [2023] 2027 for patients outside the city of New York, and for all rate periods on and after the effective date of section [2] 19 of part [P] E of chapter 57 of the laws of [2017] 2019 through March 31, [2023] 2027 for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of [alcoholism and substance abuse] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioners of mental health and [alcoholism and substance abuse] addiction services and supports, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

b. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 36, 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology. The commissioner of health shall

consult with the commissioner of [alcoholism and substance abuse] addiction services and supports and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through March 31, [2023] 2027, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [alcoholism and substance abuse] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

§ 3. Section 2 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, as amended by section 20 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, and shall expire on March 31, [2023] 2027.

§ 4. This act shall take effect immediately; provided, however that the amendments to section 1 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, made by section two of this act shall not affect the expiration of such section and shall expire therewith.

PART MM

Section 1. Section 18 of chapter 408 of the laws of 1999, constituting Kendra's law, as amended by chapter 67 of the laws of 2017, is amended to read as follows:

§ 18. This act shall take effect immediately, provided that section fifteen of this act shall take effect April 1, 2000, provided, further, that subdivision (e) of section 9.60 of the mental hygiene law as added by section six of this act shall be effective 90 days after this act shall become law; and that this act shall expire and be deemed repealed June 30, [2022] 2027.

§ 2. Paragraph 2 of subdivision (h) of section 9.60 of the mental hygiene law, as amended by chapter 158 of the laws of 2005, is amended to read as follows:

(2) The court shall not order assisted outpatient treatment unless an examining physician, who recommends assisted outpatient treatment and has personally examined the subject of the petition no more than ten days before the filing of the petition, testifies in person or by videoconference at the hearing, provided however, a physician shall only be authorized to testify by video conference when it has been shown that diligent efforts have been met to attend such hearing in person and the subject of the petition consents to the physician testifying by video conference. Such physician shall state the facts and clinical determi-

nations which support the allegation that the subject of the petition meets each of the criteria for assisted outpatient treatment.

§ 3. This act shall take effect immediately, provided, however that the amendments to section 9.60 of the mental hygiene law made by section two of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART NN

Section 1. Section 41.38 of the mental hygiene law, as amended by chapter 218 of the laws of 1988, is amended to read as follows:

§ 41.38 Rental and mortgage payments of community residential facilities for the mentally ill.

(a) "Supportive housing" shall mean, for the purpose of this section only, the method by which the commissioner contracts to provide rental support and funding for non-clinical support services in order to maintain recipient stability.

(b) Notwithstanding any inconsistent provision of this article, the commissioner may reimburse voluntary agencies for the reasonable cost of rental of or the reasonable mortgage payment or the reasonable principal and interest payment on a loan for the purpose of financing an ownership interest in, and proprietary lease from, an organization formed for the purpose of the cooperative ownership of real estate, together with other necessary costs associated with rental or ownership of property, for a community residence [or], a residential care center for adults, or supportive housing, under [his] their jurisdiction less any income received from a state or federal agency or third party insurer which is specifically intended to offset the cost of rental of the facility or housing a client at the facility, subject to the availability of appropriations therefor and such commissioner's certification of the reasonableness of the rental cost, mortgage payment, principal and interest payment on a loan as provided in this section or other necessary costs associated with rental or ownership of property, with the approval of the director of the budget.

§ 2. This act shall take effect April 1, 2022.

PART OO

Section 1. Section 4 of part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, as amended by section 1 of part U of chapter 57 of the laws of 2021, is amended to read as follows:

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016; provided, however, that sections one and two of this act shall expire and be deemed repealed on March 31, [2022] 2025.

§ 2. This act shall take effect immediately.

PART PP

Section 1. The public health law is amended by adding a new article 27-g to read as follows:

ARTICLE 27-G

ADULT CYSTIC FIBROSIS ASSISTANCE PROGRAM

Section 2795. Adult cystic fibrosis assistance program.

§ 2795. Adult cystic fibrosis assistance program. 1. The commissioner shall establish a program to reimburse the cost of providing health care or health insurance to eligible individuals who have cystic fibrosis.

2. To be a fully eligible individual for whom health care will be provided under this section, such individual:

(a) shall be at least twenty-one years old;

(b) shall have been diagnosed as having cystic fibrosis;

(c) shall have resided in the state for a minimum of twelve continuous months immediately prior to application for services under this section;

(d) shall not be eligible for medical benefits under any group or individual health insurance policy; and

(e) shall not be eligible for medical assistance pursuant to title eleven of article five of the social services law solely due to earned income.

3. To be a partially eligible individual for whom health care will be provided under this section, such individual shall meet all the criteria of a fully eligible individual except that a partially eligible individual shall be an individual who is eligible for medical benefits under any group or individual health insurance policy but which does not cover all services necessary for the care and treatment of cystic fibrosis.

4. The commissioner shall require each fully eligible individual, upon determination of eligibility, to make application to a private health insurance provider as prescribed by the commissioner for an individual health insurance policy. If and when such policy is granted, the commissioner shall approve payment for the associated premium.

5. The commissioner shall authorize payment for services related to the care and treatment of cystic fibrosis not otherwise covered by a health insurance policy. Providers of such services shall be reimbursed at the same rate and claims for payment shall be made as if such individual was eligible for benefits pursuant to title eleven of article five of the social services law.

6. All eligible individuals shall be required to contribute seven percent of their net annual income toward the cost of care and/or the cost of the annual health insurance premium.

7. The commissioner shall, in consultation with the commissioner of social services, promulgate rules and regulations necessary to implement the provisions of this article.

§ 2. This act shall take effect immediately.

PART QQ

Section 1. Subdivision 26 of section 206 of the public health law, as separately amended by chapters 45 and 322 of the laws of 2021, is amended and a new subdivision 26-a is added to read as follows:

26. (a) The commissioner [is hereby authorized and directed to], in consultation with the commissioner of addiction services and supports in relation to subparagraph (x) of this paragraph, shall review any policy or practice instituted in facilities operated by the department of corrections and community supervision, and in all local correctional facilities, as defined in subdivision sixteen of section two of the correction law, regarding:

(i) human immunodeficiency virus (HIV)[,] and acquired immunodeficiency syndrome (AIDS)[,];

(ii) hepatitis C (HCV)[, and];

(iii) COVID-19[, including the prevention of the transmission of and the treatment of such infections and diseases among incarcerated individuals];

(iv) emerging infectious diseases;

(v) women's health;

(vi) transgender health;

(vii) chronic health conditions including but not limited to asthma, diabetes, and heart disease;

(viii) health care services for individuals fifty years of age or older;

(ix) discharge planning of health care services including planning for discharges requiring residential placement or long-term care services; and

(x) substance use disorders.

(b) Such [review] reviews shall be performed at least annually, and shall focus on whether such [policy or practice is] policies or practices are consistent with current, generally accepted medical standards and procedures used to prevent the transmission of and to treat those infections and diseases among the general public. In performing such reviews, in order to determine the quality and adequacy of care and treatment provided, department personnel are authorized to enter correctional facilities and inspect policy and procedure manuals and medical protocols, interview health services providers and incarcerated individual-patients, review medical grievances, and inspect a representative sample of medical records of incarcerated individuals known to be infected with any such infections or diseases. Prior to initiating a review of a correctional system, the commissioner shall inform the public, including patients, their families and patient advocates, of the scheduled review and invite them to provide the commissioner with relevant information.

(c) Upon the completion of such review, the department shall, in writing, approve such policy or practice as instituted in facilities operated by the department of corrections and community supervision, and in any local correctional facility, or, based on specific, written recommendations, direct the department of corrections and community supervision, or the authority responsible for the provision of medical care to incarcerated individuals in local correctional facilities to prepare and implement a corrective plan to address deficiencies in areas where such policy or practice fails to conform to current, generally accepted medical standards and procedures. The commissioner shall monitor the implementation of such corrective plans and shall conduct such further reviews as the commissioner deems necessary to ensure that identified deficiencies in those policies and practices are corrected. All written reports pertaining to reviews provided for in this subdivision shall not contain individual patient identifying information and shall be [maintained, under such conditions as the commissioner shall prescribe, as] public information [available for public inspection] and shall be posted on the department's website.

(d) As used in this subdivision, "emerging infectious disease" means an infection that has increased recently or is threatening to increase in the near future.

26-a. (a) The department, in consultation with the department of corrections and community supervision, shall biennially study health care staffing in facilities operated by the department of corrections and community supervision and in local correctional facilities as

defined in subdivision sixteen of section two of the correction law. The study shall examine:

(i) adequacy of staffing, including in specialties such as women's, transgender, and geriatric health care;

(ii) potential challenges such as salary adequacy or geographic factors; and

(iii) impact of staffing levels on availability of services.

(b) The first such study shall be completed and submitted to the governor, the temporary president of the senate, and the speaker of the assembly no later than one year after the effective date of this subdivision.

§ 2. This act shall take effect immediately.

PART RR

Section 1. Paragraph (d-3) of subdivision 3 of section 364-j of the social services law, as added by section 1 of part JJ of chapter 57 of the laws of 2021, is amended to read as follows:

(d-3) Services provided in school-based health centers shall not be provided to medical assistance recipients through managed care programs established pursuant to this section [until at least April first, two thousand twenty-three,] and shall continue to be provided outside of managed care programs.

§ 2. Section 2 of part JJ of chapter 57 of the laws of 2021 amending the social services law relating to managed care programs, is amended to read as follows:

§ 2. This act shall take effect immediately [and shall expire April 1, 2023, when upon such date the provisions of this act shall be deemed repealed]; provided [further,] that the amendments to section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

§ 3. This act shall take effect immediately; provided, however, that the amendments to section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART SS

Section 1. Subdivision 3 of section 367-a of the social services law, as amended by chapter 558 of the laws of 1989, paragraph (a) as amended by chapter 81 of the laws of 1995, subparagraph 1 of paragraph (b) as designated and subparagraph 2 as added by section 41 of part C of chapter 58 of the laws of 2008, paragraph (c) as added by chapter 651 of the laws of 1990, paragraph (d) as amended by section 27 of part B of chapter 109 of the laws of 2010, paragraph (e) as added by section 16 of part D of chapter 56 of the laws of 2013, subparagraph 2 of paragraph (e) as amended by section 52 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

3. (a) As used in this subdivision, the following terms shall have the following meanings:

(1) "Qualified medicare beneficiary" means a person who is entitled to hospital insurance benefits under part A of title XVIII of the federal social security act, whose income does not exceed one hundred percent of the official federal poverty line applicable to the person's family size and whose resources do not exceed twice the maximum amount of resources a person may have in order to qualify for benefits under the federal

supplemental security income program of title XVI of the federal social security act, as determined for purposes of such program. To the extent that federal financial participation is available, a person whose resources are in excess of the amount specified in this subparagraph but otherwise meets the requirements shall be considered a "qualified medicare beneficiary".

(2) "Specified low income medicare beneficiary" means a person who would be a qualified medicare beneficiary except that person's income exceeds one hundred percent of the federal income poverty line applicable to the person's family size, but is less than one hundred twenty percent of such poverty line.

(3) "Qualified individual" means a person who is entitled to hospital insurance benefits under part A of title XVIII of the federal social security act and whose income exceeds the income level established by the state and is at least one hundred twenty percent, but less than one hundred thirty-five percent, of the federal poverty level, for a family of the size involved and who is not otherwise eligible for medical assistance under this article; referred to as a qualified individual.

(4) "Qualified disabled and working individual" means an individual who is not otherwise eligible for medical assistance and:

(i) who is entitled to enroll for hospital insurance benefits under section 1818A of part A of title XVIII of the federal social security act;

(ii) whose income does not exceed two hundred percent of the official federal poverty line applicable to the person's family size; and

(iii) whose resources do not exceed twice the maximum amount of resources that an individual or a couple, in the case of a married individual, may have and obtain federal supplemental security income benefits under title XVI of the federal social security act, as determined for purposes of that program.

For purposes of this subparagraph, income and resources are determined by the same methodology as is used for determining eligibility under the federal supplemental security income benefits under title XVI of the federal social security act.

(b) Payment of premiums for enrolling qualified disabled and working individuals and qualified medicare beneficiaries under Part A of title XVIII of the federal social security act and for enrolling such beneficiaries and eligible recipients of public assistance under part B of title XVIII of the federal social security act, together with the costs of the applicable co-insurance and deductible amounts on behalf of such beneficiaries, and recipients, and premiums under section 1839 of the federal social security act for [persons who would be qualified medicare beneficiaries except that their incomes exceed one hundred percent of the federal income poverty line applicable to the person's family size but, in calendar years nineteen hundred ninety-three and nineteen hundred ninety-four, is less than one hundred ten percent of such poverty line and, in calendar year beginning in nineteen hundred ninety-five, is less than one hundred twenty percent of such poverty line] specified low income medicare beneficiaries shall be made and the cost thereof borne by the state or by the state and social services districts, respectively, in accordance with the regulations of the department, provided, however, that the share of the cost to be borne by a social services district, if any, shall in no event exceed the proportionate share borne by such district with respect to other expenditures under this title. Moreover, if the director of the budget approves, payment of premiums for enrolling persons who have been determined to be eligi-

ble for medical assistance only may be made and the cost thereof borne or shared pursuant to this subdivision.

[(b) (1) For purposes of this subdivision, "qualified medicare beneficiaries" are those persons who are entitled to hospital insurance benefits under part A of title XVIII of the federal social security act, whose income does not exceed one hundred percent of the official federal poverty line applicable to the person's family size and whose resources do not exceed twice the maximum amount of resources a person may have in order to qualify for benefits under the federal supplemental security income program of title XVI of the federal social security act, as determined for purposes of such program.

(2) Notwithstanding any provision of subparagraph one of this paragraph to the contrary, to the extent that federal financial participation is available, a person whose resources are in excess of the amount specified but otherwise meets the requirements of subparagraph one of this paragraph shall be considered a "qualified medicare beneficiary" for the purposes of this subdivision. The commissioner is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act, to obtain the federal approvals necessary to implement this subparagraph.

(c) (1) For purposes of this subdivision, "qualified disabled and working individuals" are individuals who are not otherwise eligible for medical assistance and:

(i) who are entitled to enroll for hospital insurance benefits under section 1818A of part A of title XVIII of the federal social security act;

(ii) whose income does not exceed two hundred percent of the official federal poverty line applicable to the person's family size; and

(iii) whose resources do not exceed twice the maximum amount of resources that an individual or a couple, in the case of a married individual, may have and obtain federal supplemental security income benefits under title XVI of the federal social security act, as determined for purposes of that program.

(2) For purposes of this paragraph, income and resources are determined by the same methodology as is used for determining eligibility under the federal supplemental security income benefits under title XVI of the federal social security act.

(d)] <u>(c)</u> (1) Beginning April first, two thousand two and to the extent that federal financial participation is available at a one hundred percent federal Medical assistance percentage and subject to sections 1933 and 1902(a)(10)(E)(iv) of the federal social security act, medical assistance shall be available for full payment of medicare part B premiums for <u>qualified</u> individuals [(referred to as qualified individuals 1) who are entitled to hospital insurance benefits under part A of title XVIII of the federal social security act and whose income exceeds the income level established by the state and is at least one hundred twenty percent, but less than one hundred thirty-five percent, of the federal poverty level, for a family of the size involved and who are not otherwise eligible for medical assistance under the state plan;]<u>.</u>

(2) Premium payments for the individuals described in subparagraph one of this paragraph will be one hundred percent federally funded up to the amount of the federal allotment. The department shall discontinue enrollment into the program when the part B premium payments made pursuant to subparagraph one of this paragraph meet the yearly federal allotment.

[(3) The commissioner of health shall develop a simplified application form, consistent with federal law, for payments pursuant to this section. The commissioner of health, in cooperation with the office for the aging, shall publicize the availability of such payments to medicare beneficiaries.]

(d) Commencing April first, two thousand twenty-two, and subject to federal approval, which the commissioner shall seek, the following shall apply:

(1) For qualified medicare beneficiaries all countable income over one hundred percent of the federal poverty level, up to one hundred twenty percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions under federal and state law into account for those persons eligible pursuant to this section.

(2) For specified low income medicare beneficiaries all countable income over one hundred twenty percent of the federal poverty level, up to one hundred thirty-eight percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions under federal and state law into account for those persons eligible pursuant to this section.

(3) For qualifying individuals all countable income over one hundred thirty-eight percent of the federal poverty level, up to one hundred fifty-six percent of the federal poverty level, shall be disregarded, after taking all other disregards, deductions, and exclusions under federal and state law into account for those persons eligible pursuant to this section.

(e) (1) Payment of premiums for enrolling individuals in qualified health plans offered through a health insurance exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), shall be available to individuals who:

(i) immediately prior to being enrolled in the qualified health plan, were or would have been eligible under the family health plus program as a parent or stepparent of a child under the age of twenty-one, and whose MAGI household income, as defined in subparagraph eight of paragraph (a) of subdivision one of section three hundred sixty-six of this title, exceeds one hundred thirty-three percent of the federal poverty line for the applicable family size;

(ii) are not otherwise eligible for medical assistance under this title; and

(iii) are enrolled in a standard health plan in the silver level, as defined in 42 U.S.C. 18022.

(2) Payment pursuant to this paragraph shall be for premium obligations of the individual under the qualified health plan and shall continue only if and for so long as the individual's MAGI household income exceeds one hundred thirty-three percent, but does not exceed one hundred fifty percent, of the federal poverty line for the applicable family size, or, if earlier, until the individual is eligible for enrollment in a standard health plan pursuant to section three hundred sixty-nine-gg of this article.

(3) The commissioner of health shall submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act as may be necessary to receive federal financial participation in the costs of payments made pursuant to this paragraph; provided further, however, that nothing in this subparagraph shall be deemed to affect payments for premiums pursu-

ant to this paragraph if federal financial participation in the costs of such payments is not available.

§ 2. This act shall take effect on the thirtieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART TT

Section 1. The public health law is amended by adding a new section 3614-f to read as follows:

§ 3614-f. Fair pay for home care. 1. For the purpose of this section, "home care aide" shall have the same meaning defined in section thirty-six hundred fourteen-c of this article.

2. Beginning October first, two thousand twenty-two, the minimum wage for a home care aide shall be no less than one hundred and fifty percent of the higher of: (a) the otherwise applicable minimum wage under section six hundred fifty-two of the labor law, or (b) any otherwise applicable wage rule or order under article nineteen of the labor law.

3. Where any home care aide is paid less than required by this section, the home care aide, or the commissioner of labor acting on behalf of the home care aide, may bring an action under article six or nineteen of the labor law.

4. (a) The commissioner shall establish a regional minimum hourly base reimbursement rate for all providers employing workers subject to the minimum wage provisions established in subdivision one of this section. The regional minimum hourly base reimbursement rate shall be based on regions established by the commissioner, provided that for areas subject to section thirty-six hundred fourteen-c of this article, each area with a different prevailing rate of total compensation, as defined in that section, shall be its own region.

(b) For the purposes of this section, "regional minimum hourly base reimbursement rate" means a reimbursement rate that reflects the average combined costs associated with the provision of direct service inclusive of, but not limited to, overtime costs; all benefits; all payroll taxes, including but not limited to federal insurance contributions act, medicare, federal unemployment tax act, state unemployment insurance, disability insurance, workers' compensation, and the metropolitan transportation authority tax; related increases tied to base wages such as compression; reasonable administrative costs as defined by the commissioner; allowances for capital costs; the development of profit or reserves as allowable by law or regulations of the commissioner; and any additional supplemental payments.

(c) For home and community-based services under the 1915(c) Nursing Home Transition and Diversion and Traumatic Brain Injury Medicaid Waivers, the regional rate shall be developed in accordance with waiver rate determination methodology.

5. (a) The regional minimum hourly base reimbursement rate shall be no less than the following:

(i) thirty-eight dollars and fifty cents per hour in the wage parity region, encompassing all counties subject to section thirty-six hundred fourteen of this article; and

(ii) thirty-eight dollars and eighteen cents per hour for the counties in the remainder of the state.

(b) For consumer directed personal assistance services provided under section three hundred sixty-five-f of the social services law, the regional minimum hourly base reimbursement rate shall reflect the rates established in paragraph (a) of this subdivision, provided that the commissioner may reduce such rates by no more than twelve and nine-tenths percent. In the event that such reduction occurs, a per member, per month increase reflective of actual administrative and general costs, adjusted to reflect regional differences as regions are defined in this section, shall be made to fiscal intermediaries administering such programs. If the department or a managed care organization chooses not to utilize the per member, per month payment established pursuant to this paragraph, the regional minimum hourly base reimbursement rate for that region, as defined in paragraph (a) of this subdivision, shall apply.

6. No payment made to a provider who employs home care aides subject to this section that is less than the regional minimum hourly base reimbursement rate established by the commissioner for a region for services provided under authorization by a local department of social services, a managed care provider under section three hundred sixty-four-j of the social services law, or a managed long-term care provider under section forty-four hundred three-f of this chapter shall be deemed adequate.

(a) The commissioner shall submit any and all necessary applications for approvals and/or waivers to the federal centers for medicare and medicaid services to secure approval to establish minimum hourly base reimbursement rates and make state-directed payments to providers for the purposes of supporting wage increases.

(b) Directed payments shall be made to such providers of medicaid services through contracts with managed care organizations where applicable, provided that the commissioner ensures that such directed payments are in accordance with the terms of this section.

(c) The commissioner shall ensure that managed care capitation is adjusted to ensure rate adequacy for the managed care organizations.

7. Nothing in this section shall preclude providers employing home care aides covered under this section or payers from contracting for services at rates higher than the regional minimum hourly base reimbursement rate if the parties agree to such terms.

8. The commissioner shall publish and post regional minimum hourly base reimbursement rates annually and shall take all necessary steps to advise commercial and government programs payers of home care services of the regional minimum hourly base reimbursement rates and require other state authorized payers to reimburse providers of home care services at the minimum hourly base reimbursement rate.

§ 2. Section 3614-d of the public health law, as added by section 49 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

§ 3614-d. Universal standards for coding of payment for medical assistance claims for long term care. Claims for payment submitted under contracts or agreements with insurers under the medical assistance program for home and community-based long-term care services provided under this article, by fiscal intermediaries operating pursuant to section three hundred sixty-five-f of the social services law, and by residential health care facilities operating pursuant to article twenty-eight of this chapter shall have standard billing codes. Such insurers shall include but not be limited to Medicaid managed care plans and managed long term care plans. Such payments shall be based on universal

billing codes approved by the department or a nationally accredited organization as approved by the department; provided, however, such coding shall be consistent with any codes developed as part of the uniform assessment system for long term care established by the department and shall include, for any entity operating pursuant to this article or section three hundred sixty-five-f of the social services law that is unable to control the cumulative hours worked by an individual in a given payroll period, a code that is specific to the hourly cost of services at an overtime rate.

§ 3. Paragraph (c) of subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund Medicaid expenditures, as amended by section 1 of part CCC of chapter 56 of the laws of 2020, is amended to read as follows:

(c) Projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, minimum wage increases, increases to the mandatory base wage for home care workers pursuant to article 36 of the public health law, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund and state costs or savings from the basic health plan. Such projections may be adjusted by the director of the budget to account for increased or expedited department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

§ 4. Paragraph (a) of subdivision 3 of section 3614-c of the public health law is amended by adding a new subparagraph (v) to read as follows:

(v) for all periods on or after January first, two thousand twenty-three, the cash portion of the minimum rate of home care aide total compensation shall be the minimum wage for home care aides in the applicable region, as defined in section thirty-six hundred fourteen-f of this article. The benefit portion of the minimum rate of home care aide total compensation shall be four dollars and eighty-four cents.

§ 5. Subparagraph (iv) of paragraph (b) of subdivision 3 of section 3614-c of the public health law, as amended by section 1 of part OO of chapter 56 of the laws of 2020, is amended and a new subparagraph (v) is added to read as follows:

(iv) for all periods on or after March first, two thousand sixteen, the cash portion of the minimum rate of home care aide total compensation shall be ten dollars or the minimum wage as laid out in paragraph (b) of subdivision one of section six hundred fifty-two of the labor law, whichever is higher. The benefit portion of the minimum rate of home care aide total compensation shall be three dollars and twenty-two cents[.];

(v) for all periods on or after January first, two thousand twenty-three, the cash portion of the minimum rate of home care aide total compensation shall be the minimum wage for the applicable region, as defined in section thirty-six hundred fourteen-f of this chapter. The benefit portion of the minimum rate of home care aide total compensation shall be three dollars and eighty-nine cents.

§ 6. Severability. If any provision of this act, or any application of any provision of this act, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect

the validity or effectiveness of any other provision of this act, or of any other application of any provision of this act which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 7. This act shall take effect immediately.

PART UU

Section 1. Paragraph 7 of subdivision (c) of section 1261 of the tax law is REPEALED.

§ 2. Subparagraph (ii) of paragraph 5 of subdivision (c) of section 1261 of the tax law, as amended by section 2 of part ZZ of chapter 56 of the laws of 2020, is amended to read as follows:

(ii) After withholding the taxes, penalties and interest imposed by the city of New York on and after August first, two thousand eight as provided in subparagraph (i) of this paragraph, the comptroller shall withhold a portion of such taxes, penalties and interest sufficient to deposit annually into the central business district tolling capital lockbox established pursuant to section five hundred fifty-three-j of the public authorities law: (A) in state fiscal year two thousand nineteen - two thousand twenty, one hundred twenty-seven million five hundred thousand dollars; (B) in state fiscal year two thousand twenty - two thousand twenty-one, one hundred seventy million dollars; (C) in state fiscal year two thousand twenty-one - two thousand twenty-two and every succeeding state fiscal year, an amount equal to one hundred one percent of the amount deposited in the immediately preceding state fiscal year. The funds shall be deposited monthly in equal installments. During the period that the comptroller is required to withhold amounts and make payments described in this paragraph, the city of New York has no right, title or interest in or to those taxes, penalties and interest required to be paid into the above referenced central business district tolling capital lockbox. In addition, the comptroller shall withhold a portion of such taxes, penalties and interest in the amount of [two] <u>one</u> hundred <u>fifty</u> million dollars, to be withheld in four quarterly installments on January fifteenth, April fifteenth, July fifteenth and October fifteenth of each year, and shall deposit such amounts into the New York State Agency Trust Fund, Distressed Provider Assistance Account.

§ 3. Section 5 of part ZZ of chapter 56 of the laws of 2020 amending the tax law and the social services law relating to certain Medicaid management, is amended to read as follows:

§ 5. This act shall take effect immediately and shall be deemed repealed [two] <u>three</u> years after such effective date.

§ 4. This act shall take effect immediately; provided that the amendments to subparagraph (ii) of paragraph 5 of subdivision (c) of section 1261 of the tax law made by section two of this act shall not affect the expiration of such subparagraph and shall be deemed expired therewith.

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

§ 3. This act shall take effect immediately provided, however, that the applicable effective date of Parts A through UU of this act shall be as specifically set forth in the last section of such Parts.