STATE OF NEW YORK

S. 2507--C A. 3007--C

SENATE - ASSEMBLY

January 20, 2021

IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

IN ASSEMBLY -- 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 -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend 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 extending the Medicaid global cap (Part A); intentionally omitted (Part B); to amend part FFF of chapter 56 of the laws of 2020 relating to directing the department of health to remove the pharmacy benefit from the managed care benefit package and to provide the pharmacy benefit under the fee for service program, in relation to the effectiveness thereof (Part C); to amend the public health law, in relation to reducing the hospital capital rate add-on (Part D); intentionally omitted (Part E); to amend the public health law, in relation to telehealth distant sites and providers (Part F); to amend the public health law, in relation to authorizing the implementation of medical respite pilot programs (Part G); to amend the social services law, in relation to eliminating consumer-paid premium payments in the basic health program (Part H); intentionally omitted (Part I); intentionally omitted (Part J); 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

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

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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 K); intentionally omitted (Part L); to amend the public health law and part H of chapter 58 of the laws of 2007 amending the public health law, the public officers law and the state finance law relating to establishing the empire state stem cell board, in relation to the discontinuation of the empire clinical research investigator program (Part M); intentionally omitted (Part N); intentionally omitted (Part O); intentionally omitted (Part P); intentionally omitted (Part Q); intentionally omitted (Part R); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 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 adding an alternative payment methodology requirement; to amend chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof; to amend chapter 517 of the laws of 2016, amending the public health law relating to payments from the New York state medical indemnity fund, in relation to the effectiveness thereof; to amend the public health law, in relation to improved integration of health care and financing; to amend chapter 56 of the laws of 2014, amending the education law relating to the nurse practitioners modernization act, in relation to extending the provisions thereof; and to amend chapter 66 of the laws of 2016, amending the public health law relating to reporting of opioid overdose data, in relation to the effectiveness thereof (Part S); to amend part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part T); 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 U); to amend the mental hygiene law, in relation to requiring the final reports of such programs to be included in the statewide comprehensive plan; and to amend part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to the

effectiveness thereof (Part V); to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to extending such provisions relating thereto (Part W); relating to the office of mental health allocating funding for the 2021-22 fiscal year; and providing for the repeal of such provisions upon expiration thereof (Part X); intentionally omitted (Part Y); to amend the mental hygiene law, in relation to authorizing the charging an application processing fee for the issuance of operating certificates (Part Z); to amend the mental hygiene law and the social services law, in relation to crisis stabilization services (Part AA); intentionally omitted (Part BB); intentionally omitted (Part CC); intentionally omitted (Part DD); intentionally omitted (Part EE); intentionally omitted (Part FF); to amend the public health law, in relation to minimum direct care spending in residential health care facilities (Part GG); and to amend the executive law, in relation to the composition of the developmental disabilities planning council (Part HH); to amend the social services law, in relation to the provision of services to certain persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services (Part II); to amend the social services law, in relation to managed care programs; and providing for the repeal of such provisions upon expiration thereof (Part JJ); to amend chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, in relation to the effectiveness thereof (Part KK); to amend the social services law, in relation to requests for offers from fiscal intermediaries (Part LL); to amend the public health law, in relation to aiding in the transition to adulthood for children with medical fragility living in pediatric nursing homes and other settings; and providing for the repeal of such provisions upon expiration thereof (Part MM); to amend the social services law, in relation to providing for an exemption or disregard of income for certain individuals receiving medical assistance (Part NN); to amend part KKK of chapter 56 of the laws of 2020 amending the social services law and other laws relating to managed care encounter data, authorizing electronic notifications, and establishing regional demonstration projects, in relation to the regional demonstration program (Part OO); to amend the public health law and the social services law, in relation to post-partum extended coverage insurance coverage (Part PP); and requiring the commissioner of health to file a report on the calculation and payment of prescription drug dispensing fees to retail pharmacies by the state's medical assistance program (Part QQ)

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 2021-2022 state fiscal year. Each component is wholly contained within a Part identified as Parts A through QQ. 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. Paragraph (a) 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:

(a) For state fiscal years 2011-12 through [~~2021-22~~] **2022-23**, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a [~~monthly~~] **quarterly** basis, as reflected in [~~monthly~~] **quarterly** reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner.

§ 2. Subdivision 5 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:

5. The commissioner of health, in consultation with the director of budget, shall prepare a [~~monthly~~] **quarterly** report that sets forth:

(a) known and projected department of health medicaid expenditures as described in subdivision one of this section, and factors that could result in medicaid disbursements for the relevant state fiscal year to exceed the projected department of health state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, including spending increases or decreases due to: enrollment fluctuations, rate changes, utilization changes, MRT investments, and shift of beneficiaries to managed care; and variations in offline medicaid payments;

(b) the actions taken to implement any medicaid savings allocation adjustment implemented pursuant to subdivisions one and four of this section, including information concerning the impact of such actions on each category of service and each geographic region of the state.

(c) The price, to include the base rate plus any upcoming rate adjustment; utilization, to include current enrollment, projected enrollment changes and acuity; and Medicaid Redesign Team initiatives, one-time initiatives and other initiatives describing the proposed budget action impact, any prior year initiative with current and future year impacts for the following categories of spending:

(i) inpatient;
(ii) outpatient;
(iii) emergency room;
(iv) clinic;
(v) nursing homes;
(vi) other long term care;
(vii) medicaid managed care;
(viii) family health plus;
(ix) pharmacy;

(x) transportation;
(xi) dental;
(xii) non-institutional and all other categories;
(xiii) affordable housing;
(xiv) vital access provider services;
(xv) behavioral health vital access provider services;
(xvi) health home establishment grants;
(xvii) grants for facilitating transition of behavioral health service to managed care;
(xviii) Finger Lakes health services agency;
(xix) the transition of vulnerable populations to managed care;
(xx) audit recoveries and settlements; and
(d) where price and utilization are not applicable, detail shall be provided on spending, to include but not be limited to:
(i) demographic information of targeted recipients;
(ii) number of recipients;
(iii) award amounts;
(iv) timing of awards; and
(v) the impact of Medicaid Redesign Team and/or one-time initiatives.
Information required by paragraphs (a) and (b) of this subdivision shall be provided to the chairs of the senate finance and the assembly ways and means committees, and shall be posted on the department of health's website in the timely manner.
(e) Beginning on July 1, 2014, additional information required by paragraphs (c) and (d) of this subdivision shall be provided to the governor, the temporary president of the senate, the speaker of the assembly, 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.
(f) any projected Medicaid savings determined by the commissioner of health pursuant to section 34 of part C of a chapter of the laws of 2014, relating to the implementation of the health and mental hygiene budget, and the proposed allocation plan spending adjustment with regard to such savings.
(g) any material impact to the global cap annual projection, along with an explanation of the variance from the projection at the time of the enacted budget. Such material impacts shall include, but not be limited to, policy and programmatic changes, significant transactions, and any actions taken, administrative or otherwise, which would materially impact expenditures under the global cap. Reporting requirements under this paragraph shall include material impacts from the preceding [~~month~~] quarter and any anticipated material impacts for the [~~month~~] quarter in which the report required under this subdivision is issued, as well as anticipated material impacts for the [~~month~~] quarter subsequent to such report.
§ 3. This act shall take effect immediately.

PART B

Intentionally Omitted

PART C

Section 1. Section 1 of part FFF of chapter 56 of the laws of 2020 relating to directing the department of health to remove the pharmacy benefit from the managed care benefit package and to provide the pharma-

cy benefit under the fee for service program, is amended to read as follows:

Section 1. The Legislature hereby finds and declares that medical assistance for needy persons is a matter of public concern and a necessity in promoting the public health and welfare and for promoting the state's goal of making available to everyone, regardless of race, age, gender, national origin or economic standing, uniform, high-quality medical care. As the department of health is the single state agency responsible for supervising the administration of the state's medical assistance program (Medicaid), it is tasked with ensuring efficiency, economy, and quality of care in providing benefits to the state's needy persons. To this end and with the fiscal constraints facing our state in mind, the department of health continues to analyze the Medicaid program in search of ways to ensure Medicaid spending is held to the standard of efficiency, economy, and quality of care. In consideration of this standard, the department of health is hereby directed to exercise its existing administrative authority to remove the pharmacy benefit from managed care benefit package and instead provide the pharmacy benefit under the fee for service program, except where otherwise required by federal law, to ensure transparency and that the benefit is provided to the fullest extent and as efficiently as possible; provided, however, that the department of health shall not implement the transition of the pharmacy benefit from the managed care benefit package to the fee for service program sooner than April 1, [~~2021~~] **2023**, and until it is satisfied that all necessary and appropriate transition planning has occurred, in its sole discretion, and federal approvals have been obtained and preparations have been made. Furthermore, to ensure an orderly transition, continued access to medications, and appropriate patient education and support, the department may establish uniform standards, payment policies and reimbursement methodologies for any sites where drugs may be administered or dispensed under the fee for service program; provided that, subject to the availability of federal financial participation, when reimbursing covered entities, as defined under section 340B of the public health service act (42 U.S.C. §256b), for drugs that would otherwise be eligible for pricing under section 340B of the public health service act, the department shall examine all reasonably available methods for determining actual acquisition cost and the professional dispensing fee and, beginning in the fiscal year starting April 1, [~~2021~~] **2023**, review and adjust reimbursement for such drugs such that no sooner than April 1, [~~2023~~] **2025**, reimbursement shall be determined based on a method that the commissioner determines that utilizes the actual acquisition costs and professional dispensing fee.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART D

Section 1. Paragraph (c) of subdivision 8 of section 2807-c of the public health law, as amended by section 2 of part KK of chapter 56 of the laws of 2020, is amended to read as follows:

(c) In order to reconcile capital related inpatient expenses included in rates of payment based on a budget to actual expenses and statistics for the rate period for a general hospital, rates of payment for a general hospital shall be adjusted to reflect the dollar value of the difference between capital related inpatient expenses included in the computation of rates of payment for a prior rate period based on a budg-

et and actual capital related inpatient expenses for such prior rate period, each as determined in accordance with paragraph (a) of this subdivision, adjusted to reflect increases or decreases in volume of service in such prior rate period compared to statistics applied in determining the capital related inpatient expenses component of rates of payment based on a budget for such prior rate period. For rates effective [~~on and after~~] April first, two thousand twenty **through March thirty-first, two thousand twenty-one**, the budgeted capital-related expenses add-on as described in paragraph (a) of this subdivision, based on a budget submitted in accordance to paragraph (a) of this subdivision, shall be reduced by five percent relative to the rate in effect on such date; and the actual capital expenses add-on as described in paragraph (a) of this subdivision, based on actual expenses and statistics through appropriate audit procedures in accordance with paragraph (a) of this subdivision shall be reduced by five percent relative to the rate in effect on such date. **For rates effective on and after April first, two thousand twenty-one, the budgeted capital-related expenses add-on as described in paragraph (a) of this subdivision, based on a budget submitted in accordance to paragraph (a) of this subdivision, shall be reduced by ten percent relative to the rate in effect on such date; and the actual capital expenses add-on as described in paragraph (a) of this subdivision, based on actual expenses and statistics through appropriate audit procedures in accordance with paragraph (a) of this subdivision shall be reduced by ten percent relative to the rate in effect on such date.** For any rate year, all reconciliation add-on amounts calculated on and after April first, two thousand twenty shall be reduced by ten percent, and all reconciliation recoupment amounts calculated on or after April first, two thousand twenty shall increase by ten percent. Notwithstanding any inconsistent provision of subparagraph (i) of paragraph (e) of subdivision nine of this section, capital related inpatient expenses of a general hospital included in the computation of rates of payment based on a budget shall not be included in the computation of a volume adjustment made in accordance with such subparagraph. Adjustments to rates of payment for a general hospital made pursuant to this paragraph shall be made in accordance with paragraph (c) of subdivision eleven of this section. Such adjustments shall not be carried forward except for such volume adjustment as may be authorized in accordance with subparagraph (i) of paragraph (e) of subdivision nine of this section for such general hospital.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART E

Intentionally Omitted

PART F

Section 1. Subdivision 1 of section 2999-cc of the public health law, as added by chapter 6 of the laws of 2015, is amended to read as follows:

1. "Distant site" means a site at which a telehealth provider is located while delivering health care services by means of telehealth. **Any site within the United States or United States' territories is eligible to be a distant site for delivery and payment purposes.**

§ 2. Subdivision 3 of section 2999-cc of the public health law, as amended by section 2 of subpart C of part S of chapter 57 of the laws of 2018, is amended to read as follows:

3. "Originating site" means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth. [~~Originating sites shall be limited to: (a) facilities licensed under articles twenty-eight and forty of this chapter; (b) facilities as defined in subdivision six of section 1.03 of the mental hygiene law; (c) certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities; (d) private physician's or dentist's offices located within the state of New York; (e) any type of adult care facility licensed under title two of article seven of the social services law; (f) public, private and charter elementary and secondary schools, school age child care programs, and child day care centers within the state of New York; and (g) the patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York.~~]

§ 3. Paragraphs (w) and (x) of subdivision 2 of section 2999-cc of the public health law, as amended by section 1 of part HH of chapter 56 of the laws of 2020, are amended to read as follows:

(w) a care manager employed by or under contract to a health home program, patient centered medical home, office for people with developmental disabilities Care Coordination Organization (CCO), hospice or a voluntary foster care agency certified by the office of children and family services certified and licensed pursuant to article twenty-nine-i of this chapter; [~~and~~]

(x) **certified peer recovery advocate services providers certified by the commissioner of addiction services and supports pursuant to section 19.18-b of the mental hygiene law, peer providers credentialed by the commissioner of addiction services and supports and peers certified or credentialed by the office of mental health; and**

(y) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, or the commissioner of the office for people with developmental disabilities pursuant to regulation.

§ 4. This act shall take effect April 1, 2021; provided, however, if this act shall have become a law after such date it shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART G

Section 1. The public health law is amended by adding a new article 29-J to read as follows:

ARTICLE 29-J

MEDICAL RESPITE PROGRAM

Section 2999-hh. Medical respite program.

§ 2999-hh. Medical respite program. 1. Definitions. As used in this article, the following terms shall have the following meanings, unless the context clearly otherwise requires:

(a) "Medical respite program" means a not-for-profit corporation certified pursuant to subdivision two of this section to serve recipients whose prognosis or diagnosis necessitates the receipt of:

(i) Temporary room and board; and

(ii) The provision or arrangement of the provision of health care and support services; provided, however, that the operation of a medical respite program shall be separate and distinct from any housing programs offered to individuals who do not qualify as recipients.

(b) "Recipient" means an individual who:

(i) Has a qualifying health condition that requires treatment or care;

(ii) Does not require hospital inpatient, observation unit, or emergency room level of care, or a medically indicated emergency department or observation visit; and

(iii) Is experiencing homelessness or at imminent risk of homelessness. A person shall be deemed "homeless" if they lack a fixed, regular and adequate nighttime residence in a location ordinarily used as a regular sleeping accommodation for people; provided, however, that an operator of a medical respite program shall be permitted to specialize by providing services to a subpopulation of homeless recipients if necessary to respond to community need or ensure the availability of a funding source that will support the medical respite program's operations, and such limitations are otherwise consistent with any rules or regulations made pursuant to this section.

2. Certification. (a) Notwithstanding any inconsistent provision of law, the commissioner may certify a not-for-profit corporation as an operator of a medical respite program.

(b) The commissioner may make regulations to establish procedures to review and approve applications for a certification pursuant to this article, which shall, at a minimum, specify standards for: recipient eligibility; medical respite program services that shall be provided; physical environment; staffing; and policies and procedures governing health and safety, length of stay, referrals, discharge, and coordination of care.

3. Operating standards; responsibility for standards. (a) Medical respite programs certified pursuant to this article shall:

(i) Provide recipients with temporary room and board; and

(ii) Provide, or arrange for the provision of, health care and support services to recipients.

(b) Nothing in this article shall affect the application, qualification, or requirements that may apply to an operator with respect to any other licenses or operating certificates that such operator may hold, including, without limitation, under article twenty-eight of this chapter or article seven of the social services law.

4. Temporary accommodation. A medical respite program shall be considered a form of emergency shelter or temporary shelter for purposes of determining a recipient's eligibility for housing programs or benefits administered by the state or by a local social services district, including programs or benefits that support access to accommodations of a temporary, transitional, or permanent nature. No claim of recovery shall accrue against a recipient to recover the cost of care and services provided under this article. Care and services provided under this article shall not be deemed public benefits that would affect a recipient's immigration status under federal law.

5. Inspections and compliance. The commissioner shall have the authority to inquire into the operation of any certified medical respite program and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care and services, system of accounts, records, and the adequacy of financial resources and sources of future revenues.

6. Suspension or revocation of certification. (a) A certification for a medical respite program may be revoked, suspended, limited, annulled or denied by the commissioner, in consultation with either the commissioners of the office of mental health, the office of temporary and disability assistance, or the office of addiction services and supports, as appropriate based on a determination of the department depending on the diagnosis or stated needs of the individuals being served or proposed to be served in the medical respite program, if an operator is determined to have failed to comply with this article or the rules and regulations made pursuant to this section. No action taken against an operator under this subdivision shall affect an operator's other licenses or certifications; provided however, that the facts that gave rise to the revocation, suspension, limitation, annulment or denial of certification may also form the basis of a limitation, suspension of revocation of such other licenses or certifications.

(b) No medical respite program certification shall be revoked, suspended, limited, annulled or denied without a hearing; provided that a certification may be temporarily suspended or limited without a hearing for a period not in excess of thirty days upon written notice that the continuation of the medical respite program places the health or safety of the recipients in imminent danger, and that the action is in the interest of the recipients. However, the department shall not make a determination until the program has had a reasonable opportunity, following the initial determination that the program places the health or safety of the recipients in imminent danger, to correct its deficiencies and following this period, which shall be up to thirty calendar days, has been given written notice and opportunity for hearing.

(c) Nothing in this section shall prevent the commissioner from imposing sanctions or penalties on a medical respite program that are authorized under any other law or regulation.

7. The commissioner shall promulgate regulations to implement this article.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART H

Section 1. The title heading of title 11-D of article 5 of the social services law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

[~~FAMILY~~] BASIC HEALTH [~~PLUS~~] PROGRAM

§ 2. Paragraphs (c) and (e) of subdivision 1, paragraph (d) of subdivision 3, subdivision 5 and subdivision 7 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 and subdivision 7 as renumbered by section 28 of part B of chapter 57 of the laws of 2015, are 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;

(e) "Basic health insurance plan" means a standard health plan **providing health care services**, separate and apart from qualified health plans, that is issued by an approved organization and certified in accordance with this section.

(d) (i) 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.

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.

5. Premiums and cost sharing. (a) Subject to federal approval, the commissioner shall establish premium payments enrollees shall pay to approved organizations for coverage of health care services pursuant to this title. [~~Such premium payments shall be established in the following manner:~~

~~(i) up to twenty dollars monthly for an individual with a household income above one hundred and fifty percent of the federal poverty line but 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) no~~] **No** payment is required for individuals with a household income at or below [~~one hundred and fifty~~] **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.

(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.**

7. Any funds transferred by the secretary of health and human services to the state pursuant to 42 U.S.C. 18051(d) shall be deposited in trust. Funds from the trust shall be used for providing health benefits through an approved organization, which, at a minimum, shall include essential health benefits as defined in 42 U.S.C. 18022(b); to reduce the premiums**, if any,** and cost sharing of participants in the basic health program; or for such other purposes as may be allowed by the secretary of health and human services. Health benefits available through the basic health program shall be provided by one or more approved organizations pursuant to an agreement with the department of health and shall meet the requirements of applicable federal and state laws and regulations.

§ 3. This act shall take effect June 1, 2021 and shall expire and be deemed repealed should federal approval be withdrawn or 42 U.S.C. 18051 be repealed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the withdrawal of federal approval or the repeal of 42 U.S.C. 18051 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 I

Intentionally Omitted

PART J

Intentionally Omitted

PART K

Section 1. 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 AAA of chapter 56 of the laws of 2020, 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, [~~and~~] between July 1, 2020 and June 30, 2021**, and between July 1, 2021 and June 30, 2022** 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, [~~and~~] between July 1, 2020 and June 30, 2021**, and between July 1, 2021 and June 30, 2022** 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.

§ 2. 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 AAA of chapter 56 of the laws of 2020, 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, [~~and~~] between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, [~~and~~] 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, [~~and~~] between July 1, 2020 and June 30, 2021**, and between July 1, 2021 and June 30, 2022** 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, [~~and~~] between July 1, 2020 and June 30, 2021**, and between July 1, 2021 and June 30, 2022** 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, [~~and~~] to the period July 1, 2020 to June 30, 2021**, and to the period July 1, 2021 to June 30, 2022**.

§ 3. 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 AAA of chapter 56 of the laws of 2020, 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, [~~and~~] during the period July 1, 2020 to June 30, 2021**, and during the period July 1, 2021 to June 30, 2022** 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** 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** 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 accordance 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** 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** 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** for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 4. 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 5 of part AAA of chapter 56 of the laws of 2020, 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, [~~2021~~] **2022**; 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, [~~2021~~] **2022**, 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, [~~2021~~] **2022** 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.

§ 5. 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 6 of part AAA of chapter 56 of the laws of 2020, 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, [~~and~~] June 15, 2021**, and June 15, 2022** 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** 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** 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, [~~and~~] June 15, 2021**, and June 15, 2022** as applicable.

§ 6. 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 7 of part AAA of chapter 56 of the laws of 2020, 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~~] **twenty-one**, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [~~twenty~~] **twenty-one**; 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~~] **twenty-one** exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [~~twenty~~] **twenty-one**, 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~~] **twenty-one**, 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~~] **twenty-one** 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~~] twenty-one.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART L

Intentionally Omitted

PART M

Section 1. Subdivision 1 of section 265-a of the public health law, as added by section 1 of part H of chapter 58 of the laws of 2007, is amended to read as follows:

1. The empire state stem cell board ("board"), comprised of a funding committee and an ethics committee, both of which shall be chaired by the commissioner, is hereby created within the department for the purpose of administering the empire state stem cell trust fund ("fund"), created pursuant to section ninety-nine-p of the state finance law. The board is hereby empowered, subject to annual appropriations and other funding authorized or made available, to make grants to basic, applied, translational or other research and development activities that will advance scientific discoveries in fields related to stem cell biology; provided, however, that the board shall not make any grants on or after April first, two thousand twenty-one.

§ 2. Section 4 of part H of chapter 58 of the laws of 2007 amending the public health law, the public officers law and the state finance law relating to establishing the empire state stem cell board, 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, 2007 and shall expire and be deemed repealed December 31, 2025.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021; provided, however, the amendments to section 265-a of the public health law made by section one of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART N

Intentionally Omitted

PART O

Intentionally Omitted

PART P

Intentionally Omitted

PART Q

Intentionally Omitted

PART R

Intentionally Omitted

PART S

Section 1. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 3 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 11. This act shall take effect immediately and:

(a) sections one and three shall expire on December 31, 1996,

(b) sections four through ten shall expire on June 30, [~~2021~~] **2023**, and

(c) provided that the amendment to section 2807-b of the public health law by section two of this act shall not affect the expiration of such section 2807-b as otherwise provided by law and shall be deemed to expire therewith.

§ 2. Subdivision (a) of section 40 of part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, as amended by section 5 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(a) sections two, three, three-a, three-b, three-c, three-d, three-e and twenty-one of this act shall take effect July 1, 2010; sections fifteen, sixteen, seventeen, eighteen and nineteen of this act shall take effect January 1, 2011; and provided further that section twenty of this act shall be deemed repealed [~~ten~~] **sixteen** years after the date the contract entered into pursuant to section 365-h of the social services law, as amended by section twenty of this act, is executed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the execution of the contract entered into pursuant to section [~~367-h~~] **365-h** of the social services law 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;

§ 3. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 12 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021**, and on and after April 1, 2021 through March 31, 2023**;

§ 4. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 13 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021**, and on and after April 1, 2021 through March 31, 2023**.

§ 5. Section 4-a of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 14 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2017 through March 31, [~~2021~~] **2023**, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2017, 2018, 2019, 2020, [~~and~~] 2021**, 2022 and 2023** calendar years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2017, 2018, 2019, 2020, [~~and~~] 2021**, 2022 and 2023** calendar years shall also be applied to rates of payment provided on and after January 1, 2017 through March 31, [~~2021~~] **2023** for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations; and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2017 through March 31, [~~2021~~] **2023**, such trend factors attributable to the 2017, 2018, 2019, 2020, [~~and~~] 2021**, 2022 and 2023** calendar years shall be established at no greater than zero percent.

§ 6. Subdivision 2 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 17 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and

after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, 2015 and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021**, and on and after April 1, 2021 through March 31, 2023**;

§ 7. Section 7 of part H of chapter 57 of the laws of 2019, amending the public health law relating to waiver of certain regulations, as amended by section 11 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019, provided, however, that section two of this act shall expire on April 1, [~~2021~~] **2022**.

§ 8. Section 5 of chapter 517 of the laws of 2016, amending the public health law relating to payments from the New York state medical indemnity fund, as amended by section 18 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

§ 5. This act shall take effect on the forty-fifth day after it shall have become a law, provided that the amendments to subdivision 4 of section 2999-j of the public health law made by section two of this act shall take effect on June 30, 2017 and shall expire and be deemed repealed December 31, [~~2021~~] **2022**.

§ 9. Subdivision 1 of section 2999-aa of the public health law, as amended by chapter 80 of the laws of 2017, is amended to read as follows:

1. In order to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York, it shall be the policy of the state to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and acquisitions among health care providers or among others who might otherwise be competitors, under the active supervision of the commissioner. To the extent such arrangements, or the planning and negotiations that precede them, might be anti-competitive within the meaning and intent of the state and federal antitrust laws, the intent of the state is to supplant competition with such arrangements under the active supervision and related administrative actions of the commissioner as necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws with respect to activities undertaken by health care providers and others pursuant to this article, where the benefits of such active supervision, arrangements and actions of the commissioner outweigh any disadvantages likely to result from a reduction of competition. The commissioner shall not approve an arrangement for which state action immunity is sought under this article without first consulting with, and receiving a recommendation from, the public health and health planning council. No arrangement under this article shall be approved after December thirty-first, two thousand [~~twenty~~] **twenty-four**.

§ 10. Section 3 of part D of chapter 56 of the laws of 2014, amending the education law relating to the nurse practitioners modernization act, 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 [~~sixth~~] **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.

§ 11. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 9 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand nineteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand nineteen through March thirty-first, two thousand twenty-one such assessment shall be six percent**, and further provided that for all such gross receipts received on or after April first, two thousand twenty-one through March thirty-first, two thousand twenty-three such assessment shall be six percent**.

§ 12. Section 2 of chapter 66 of the laws of 2016, amending the public health law relating to reporting of opioid overdose data, is amended to read as follows:

§ 2. This act shall take effect immediately, provided that subdivision 6 of section 3309 of the public health law, as added by section one of this act, shall expire and be deemed repealed March 31, [~~2021~~] **2026**.

§ 13. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2021.

PART T

Section 1. Section 3 of part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, as amended by section 1 of part X of chapter 57 of the laws of 2018, is amended to read as follows:

§ 3. This act shall take effect immediately; and shall expire and be deemed repealed June 30, [~~2021~~] 2024.

§ 2. This act shall take effect immediately.

PART U

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, 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, [~~2021~~] 2022.

§ 2. This act shall take effect immediately.

PART V

Section 1. Section 2 of part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, as amended by section 1 of part U of chapter 57 of the laws of 2018, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [~~2021~~] 2024.

§ 2. Subdivision (d) of section 41.35 of the mental hygiene law, as amended by chapter 658 of the laws of 1977, is amended to read as follows:

(d) Quarterly reviews and evaluations of the program shall be undertaken and a final report shall be developed by representatives of the commissioner or commissioners having jurisdiction over the services and the local governmental unit assessing the program, indicating its potential for continuation or use elsewhere, and making any further recommendations related to the program. Copies of such quarterly evaluations and final reports shall be sent no later than November fifteenth to the director of the division of the budget, and the chairmen of the senate finance committee and the assembly committee on ways and means and such final reports shall be included in the relevant commissioner or commissioners statewide comprehensive plan pursuant to section 5.07 of this chapter.

§ 3. Subparagraphs f and g of paragraph 1 of subdivision (b) of section 5.07 of the mental hygiene law, as amended by section 3 of part N of chapter 56 of the laws of 2012, are amended and a new subparagraph h is added to read as follows:

f. encourage and promote person-centered, culturally and linguistically competent community-based programs, services, and supports that reflect the partnership between state and local governmental units; [~~and~~]

g. include progress reports on the implementation of both short-term and long-term recommendations of the children's plan required pursuant to section four hundred eighty-three-f of the social services law[~~.~~]; and

h. include final reports for time-limited demonstration programs pursuant to subdivision (d) of section 41.35 of this chapter.

§ 4. This act shall take effect immediately.

PART W

Section 1. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section 1 of part V of chapter 57 of the laws of 2018, is amended to read as follows:

§ 7. This act shall take effect immediately and shall expire March 31, [~~2021~~] 2024 when upon such date the provisions of this act shall be deemed repealed.

§ 2. This act shall take effect immediately.

PART X

Section 1. Notwithstanding section 41.55 of the mental hygiene law, the office of mental health shall not be required to allocate funding for fiscal year 2021-22 pursuant to the provisions of such section and such law.

§ 2. This act shall take effect immediately and shall expire March 31, 2022 when upon such date the provisions of this act shall be deemed repealed.

PART Y

Intentionally Omitted

PART Z

Section 1. Subdivision (a) of section 31.04 of the mental hygiene law is amended by adding a new paragraph 8 to read as follows:

8. establishing a schedule of fees for the purpose of processing applications for the issuance of operating certificates. All fees pursuant to this section shall be payable to the office for deposit into the general fund.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the commissioner of mental health is authorized to promulgate any and all rules and regulations and take any other measures necessary to implement this act on its effective date or before such date.

PART AA

Section 1. The mental hygiene law is amended by adding a new section 31.36 to read as follows:

§ 31.36 Crisis stabilization services.

The commissioner shall be authorized, in conjunction with the commissioner of the office of addiction services and supports, to create crisis stabilization centers within New York state in accordance with article thirty-six of this title, including the promulgation of joint regulations and implementation of a financing mechanism to allow for the sustainable operation of such programs.

§ 2. The mental hygiene law is amended by adding a new section 32.36 to read as follows:

§ 32.36 Crisis stabilization services.

The commissioner shall be authorized, in conjunction with the commissioner of the office of mental health, to create crisis stabilization centers within New York state in accordance with article thirty-six of this title, including the promulgation of joint regulations and implementation of a financing mechanism to allow for the sustainable operation of such programs.

§ 3. The mental hygiene law is amended by adding a new article 36 to read as follows:

ARTICLE XXXVI

ADDICTION AND MENTAL HEALTH SERVICES AND SUPPORTS

Section 36.01 Crisis stabilization centers.

36.02 Referral to crisis stabilization centers.

§ 36.01 Crisis stabilization centers.

(a) (1) The commissioners are authorized to jointly license crisis stabilization centers subject to the availability of state and federal funding.

(2) A crisis stabilization center shall serve as a voluntary and urgent service provider for persons at risk of a mental health or substance abuse crisis or who are experiencing a crisis related to a psychiatric and/or substance use disorder that are in need of crisis stabilization services. Each crisis stabilization center shall provide or contract to provide person centered and patient driven crisis stabilization services for mental health or substance use twenty-four hours per day, seven days per week, including but not limited to:

(i) Engagement, triage and assessment;

(ii) Continuous observation;

(iii) Mild to moderate detoxification;

(iv) Sobering services;

(v) Therapeutic interventions;

(vi) Discharge and after care planning;

(vii) Telemedicine;

(viii) Peer support services; and

(ix) Medication assisted treatment.

(3) The commissioners shall require each crisis stabilization center to submit a plan. The plan shall be approved by the commissioners prior to the issuance of a license pursuant to this article. Each plan shall include:

(i) a description of the center's catchment area,

(ii) a description of the center's crisis stabilization services,

(iii) agreements or affiliations with hospitals as defined in section 1.03 of this chapter,

(iv) agreements or affiliations with general hospitals or law enforcement to receive persons,

(v) a description of local resources available to the center to prevent unnecessary hospitalizations of persons,

(vi) a description of the center's linkages with local police agencies, emergency medical services, ambulance services and other transportation agencies,

(vii) a description of local resources available to the center to provide appropriate community mental health and substance use disorder services upon release,

(viii) written criteria and guidelines for the development of appropriate planning for persons in need of post community treatment or services,

(ix) a statement indicating that the center has been included in an approved local services plan developed pursuant to article forty-one of this chapter for each local government located within the center's catchment area; and

(x) any other information or agreements required by the commissioners.

(4) Crisis stabilization centers shall participate in county and community planning activities annually, and as additionally needed, in order to participate in local community service planning processes to ensure, maintain, improve or develop community services that demonstrate recovery outcomes. These outcomes include, but are not limited to, quality of life, socio-economic status, entitlement status, social networking, coping skills and reduction in use of crisis services.

(b) Each crisis stabilization center shall be staffed with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, which shall include, but not be limited to, at least one psychiatrist or psychiatric nurse practitioner, a credentialed alcoholism and substance abuse counselor and one peer support specialist on duty and available at all times.

(c) The commissioners shall promulgate regulations necessary to the operation of such crisis stabilization centers.

(d) Where a crisis stabilization center has been established prior to the effective date of this article, the previously established center may be issued a license where the provider can demonstrate substantial compliance with minimum crisis service standards necessary for patient safety and program efficacy.

(e) For the purpose of addressing unique rural service delivery needs and conditions, the commissioners shall provide technical assistance for the establishment of crisis stabilization centers otherwise approved under the provisions of this section, including technical assistance to promote and facilitate the establishment of such centers in rural areas in the state or combinations of rural counties.

(f) The commissioners shall develop guidelines for educational materials to assist crisis stabilization centers in educating local practitioners, community mental health and substance abuse programs, hospitals, law enforcement and peers. Such materials shall include appropriate education relating to de-escalation techniques, cultural competency, the recovery process, mental health, substance use, and avoidance of aggressive confrontation.

(g) Within the amounts appropriated, the commissioners shall arrange for appropriate training to law enforcement entities, first responders, and any other entities deemed appropriate by the commissioners, located within the catchment area of a crisis stabilization center. The training may include but not be limited to: (1) crisis intervention team training; (2) mental health first aid; (3) implicit bias training; and (4) naloxone training. Such training may be provided in an electronic format or other format as deemed appropriate by the commissioners. The commis-

sioners may contract with an organization with the knowledge and expertise in providing the training required under this subdivision.

§ 36.02 Referral to crisis stabilization centers.

(a) A referral to crisis stabilization centers may include but not be limited to: (1) walk-ins or self-referrals; (2) family members; (3) schools; (4) hospitals; (5) community-based providers; (6) mobile mental health crisis teams; (7) crisis call centers; (8) primary care doctors; (9) law enforcement; and (10) private practitioners.

(b) All services provided in crisis stabilization centers shall be voluntary. No crisis stabilization center shall accept involuntary referrals, and no person shall be forced or coerced to participate in services or treatment. A crisis stabilization center may at any time refer a person in their care to a higher level of treatment if deemed appropriate.

(c) For a person who is in need of emergency observation under section 9.41, 9.43, 9.45, or 9.58 of this chapter, the appropriate police officer, peace officer, court, community services director or mobile crisis team must inform the person of the crisis stabilization center services where available. A crisis stabilization center may conduct an assessment prior to accepting a referral. A crisis stabilization center may make a referral to a hospital or comprehensive psychiatric emergency program if an assessment determines that they are unable to meet the service needs of a person.

§ 4. Section 9.41 of the mental hygiene law, as amended by chapter 723 of the laws of 1989, is amended to read as follows:

§ 9.41 Emergency [~~admissions~~] assessment for immediate observation, care, and treatment; powers of certain peace officers and police officers.

(a) Any peace officer, when acting pursuant to his or her special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. Such officer may direct the removal of such person or remove him or her to any hospital specified in subdivision (a) of section 9.39 of this article, or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40 of this article, or[~~,~~] pending his or her examination or admission to any such hospital or program, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action.

(b) A person otherwise determined to meet the criteria for an emergency assessment pursuant to this section may voluntarily agree to be transported to a crisis stabilization center under section 36.01 of this chapter for care and treatment and, in accordance with this article, an assessment by the crisis stabilization center determines that they are able to meet the service needs of the person.

§ 5. Section 9.43 of the mental hygiene law, as amended by chapter 723 of the laws of 1989, is amended to read as follows:

§ 9.43 Emergency [~~admissions~~] assessment for immediate observation, care, and treatment; powers of courts.

(a) Whenever any court of inferior or general jurisdiction is informed by verified statement that a person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to

result in serious harm to himself or herself, such court shall issue a warrant directing that such person be brought before it. If, when said person is brought before the court, it appears to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm to himself or herself or others, the court shall issue a civil order directing his or her removal to any hospital specified in subdivision (a) of section 9.39 **of this article** or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40 **of this article**, **or to any crisis stabilization center specified in section 36.01 of this chapter when the court deems such center is appropriate and where such person voluntarily agrees; that is** willing to receive such person for a determination by the director of such hospital [~~or~~], program **or center** whether such person should be [~~retained~~] **received** therein pursuant to such section.

(b) Whenever a person before a court in a criminal action appears to have a mental illness which is likely to result in serious harm to himself or herself or others and the court determines either that the crime has not been committed or that there is not sufficient cause to believe that such person is guilty thereof, the court may issue a civil order as above provided, and in such cases the criminal action shall terminate.

§ 6. Section 9.45 of the mental hygiene law, as amended by chapter 723 of the laws of 1989 and the opening paragraph as amended by chapter 192 of the laws of 2005, is amended to read as follows:

§ 9.45 Emergency [~~admissions~~] **assessment** for immediate observation, care, and treatment; powers of directors of community services.

(a) The director of community services or the director's designee shall have the power to direct the removal of any person, within his or her jurisdiction, to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 of this article, or to a comprehensive psychiatric emergency program pursuant to subdivision (a) of section 9.40 of this article, if the parent, adult sibling, spouse or child of the person, the committee or legal guardian of the person, a licensed psychologist, registered professional nurse or certified social worker currently responsible for providing treatment services to the person, a supportive or intensive case manager currently assigned to the person by a case management program which program is approved by the office of mental health for the purpose of reporting under this section, a licensed physician, health officer, peace officer or police officer reports to him or her that such person has a mental illness for which immediate care and treatment [~~in a hospital~~] is appropriate and which is likely to result in serious harm to himself or herself or others. It shall be the duty of peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department to assist representatives of such director to take into custody and transport any such person. Upon the request of a director of community services or the director's designee an ambulance service, as defined in subdivision two of section three thousand one of the public health law, is authorized to transport any such person. Such person may then be retained in a hospital pursuant to the provisions of section 9.39 of this article or in a comprehensive psychiatric emergency program pursuant to the provisions of section 9.40 of this article.

(b) A person otherwise determined to meet the criteria for an emergency assessment pursuant to this section may voluntarily agree to be

transported to a crisis stabilization center under section 36.01 of this chapter for care and treatment and, in accordance with this article, an assessment by the crisis stabilization center determines that they are able to meet the service needs of the person.

§ 7. Subdivision (a) of section 9.58 of the mental hygiene law, as added by chapter 678 of the laws of 1994, is amended to read as follows:

(a) A physician or qualified mental health professional who is a member of an approved mobile crisis outreach team shall have the power to remove, or pursuant to subdivision (b) of this section, to direct the removal of any person who appears to be mentally ill and is conducting themselves in a manner which is likely to result in serious harm to themselves or others, to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 or section 31.27 of this chapter [~~for the purpose of evaluation for admission if such person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others~~] or where the team physician or qualified mental health professional deems appropriate and where the person voluntarily agrees, to a crisis stabilization center specified in section 36.01 of this chapter.

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

(gg) addiction and mental health services and supports provided by facilities licensed pursuant to article thirty-six of the mental hygiene law.

§ 9. Paragraph 5 of subdivision (a) of section 22.09 of the mental hygiene law, as amended by section 1 of part D of chapter 69 of the laws of 2016, is amended to read as follows:

5. "Treatment facility" means a facility designated by the commissioner which may only include a general hospital as defined in article twenty-eight of the public health law, or a medically managed or medically supervised withdrawal, inpatient rehabilitation, or residential stabilization treatment program that has been certified by the commissioner to have appropriate medical staff available on-site at all times to provide emergency services and continued evaluation of capacity of individuals retained under this section or a crisis stabilization center licensed pursuant to article 36.01 of this chapter.

§ 10. Subparagraph (B) of paragraph 31 of subsection (i) of section 3216 of the insurance law, as amended by section 6 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(B) Coverage under this paragraph may be limited to facilities in [~~New York~~] this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] addiction services and supports to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to section 36.01 of the mental hygiene law, and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence substance abuse treatment programs and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located.

§ 11. Paragraph 31 of subsection (i) of section 3216 of the insurance law is amended by adding a new subparagraph (I) to read as follows:

(I) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the insurer's provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this subparagraph may be

reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 12. Item (i) of subparagraph (A) of paragraph 35 of subsection (i) of section 3216 of the insurance law, as added by section 8 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

§ 13. Paragraph 35 of subsection (i) of section 3216 of the insurance law is amended by adding a new subparagraph (H) to read as follows:

(H) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the insurer's provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 14. Item (i) of subparagraph (A) of paragraph 5 of subsection (l) of section 3221 of the insurance law, as amended by section 13 of subpart A of part BB of chapter 57 of the laws of 2019, is amended as follows:

(i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

§ 15. Paragraph 5 of subsection (l) of section 3221 of the insurance law is amended by adding a new subparagraph (H) to read as follows:

(H) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the insurer's provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 16. Subparagraph (B) of paragraph 7 of subsection (l) of section 3221 of the insurance law, as amended by section 16 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(B) Coverage under this paragraph may be limited to facilities in [~~New York~~] this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] addiction services and supports to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to section 36.01 of the mental hygiene law, and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence treatment programs and similarly licensed, certified or otherwise authorized in the state in which the facility is located.

§ 17. Paragraph 7 of subsection (l) of section 3221 of the insurance law is amended by adding a new subparagraph (I) to read as follows:

(I) This subparagraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the insurer's provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 18. Paragraph 1 of subsection (g) of section 4303 of the insurance law, as amended by section 22 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(1) where the contract provides coverage for inpatient hospital care, benefits for in-patient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or for inpatient care provided in other states, to similarly licensed hospitals, and benefits for out-patient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law or in a facility operated by the office of mental health or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law or for out-patient care provided in other states, to similarly certified facilities; and

§ 19. Subsection (g) of section 4303 of the insurance law is amended by adding a new paragraph 9 to read as follows:

(9) This paragraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the corporation's provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this paragraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

§ 20. Paragraph 2 of subsection (l) of section 4303 of the insurance law, as amended by section 27 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(2) Coverage under this subsection may be limited to facilities in [~~New York~~] this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse services~~] addiction services and supports to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to section 36.01 of the mental hygiene law, and, in other states, to those

which are accredited by the joint commission as alcoholism or chemical dependence substance abuse treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

§ 21. Subsection (l) of section 4303 of the insurance law is amended by adding a new paragraph 9 to read as follows:

(9) This paragraph shall apply to crisis stabilization centers in this state that are licensed pursuant to section 36.01 of the mental hygiene law and participate in the corporation's provider network. Benefits for care in a crisis stabilization center shall not be subject to preauthorization. All treatment provided under this paragraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

§ 22. The commissioner of health, in consultation with the office of mental health and the office of addiction services and supports, shall seek Medicaid federal financial participation from the federal centers for Medicare and Medicaid services for the federal share of payments for the services authorized pursuant to this part.

§ 23. This act shall take effect October 1, 2021; provided, however, that the amendments to sections 9.41, 9.43 and 9.45 of the mental hygiene law made by sections four, five and six of this act shall not affect the expiration of such sections and shall expire therewith; and provided, further, however, that sections ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, and twenty-one of this act shall apply to policies and contracts issued, renewed, modified, altered or amended on or after January 1, 2022. 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 BB

Intentionally Omitted

PART CC

Intentionally Omitted

PART DD

Intentionally Omitted

PART EE

Intentionally Omitted

PART FF

Intentionally Omitted

PART GG

Section 1. The public health law is amended by adding a new section 2828 to read as follows:

§ 2828. Residential health care facilities; minimum direct resident care spending. 1. (a) Notwithstanding any law to the contrary, the department shall promulgate regulations governing the disposition of revenue in excess of expenses for residential health care facilities consistent with this section. Beginning on and after January first, two thousand twenty-two, every residential health care facility shall spend a minimum of seventy percent of revenue on direct resident care, and forty percent of revenue shall be spent on resident-facing staffing, provided that amounts spent on resident-facing staffing shall be included as a part of amounts spent on direct resident care.

(b) Fifteen percent of costs associated with resident-facing staffing contracted out by a facility for services provided by registered professional nurses or licensed practical nurses licensed pursuant to article one hundred thirty-nine of the education law or certified nurse aides who have completed certification and training approved by the department shall be deducted from the calculation of the amount spent on resident-facing staffing and direct resident care.

(c) Such regulations shall further include at a minimum that any residential health care facility for which total operating revenue exceeds total operating and non-operating expenses by more than five percent of total operating and non-operating expenses or that fails to spend the minimum amount necessary to comply with the minimum spending standards for resident-facing staffing or direct resident care, calculated on an annual basis, shall remit such excess revenue, or the difference between the minimum spending requirement and the actual amount of spending on resident-facing staffing or direct care staffing, as the case may be, to the state, with such excess revenue which shall be payable, in a manner to be determined by such regulations, by November first in the year following the year in which the expenses are incurred. The department shall collect such payments by methods including, but not limited to, bringing suit in a court of competent jurisdiction on its own behalf after giving notice of such suit to the attorney general, deductions or offsets from payments made pursuant to the Medicaid program, and shall deposit such recouped funds into the nursing home quality pool, as set forth in paragraph d of subdivision two-c of section two thousand eight hundred eight of this article. Provided further that such payments of excess revenue shall be in addition to and shall not affect a residential health care facility's obligations to make any other payments required by state or federal law into the nursing home quality pool, including but not limited to medicaid rate reductions required pursuant to paragraph g of subdivision two-c of section two thousand eight hundred eight of this article and department regulations promulgated pursuant thereto. The commissioner or their designees shall have authority to audit the residential health care facilities' reports for compliance in accordance with this section.

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

(a) "Revenue" shall mean the total operating revenue from or on behalf of residents of the residential health care facility, government payers, or third-party payers, to pay for a resident's occupancy of the residential health care facility, resident care, and the operation of the residential health care facility as reported in the residential health care facility cost reports submitted to the department; provided, however,

that revenue shall exclude the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years.

(b) "Expenses" shall include all operating and non-operating expenses, before extraordinary gains, reported in cost reports submitted pursuant to section twenty-eight hundred five-e of this article, except as expressly excluded by regulations and/or this section. Such exclusions shall include, but not be limited to, any related party transaction or compensation to the extent that the value of such transaction is greater than fair market value, and the payment of compensation for employees who are not actively engaged in or providing services at the facility.

(c) "Direct resident care" includes the following cost centers in the residential health care facility cost report: (i) Nonrevenue Support Services - Plant Operation & Maintenance, Laundry and Linen, Housekeeping, Patient Food Service, Nursing Administration, Activities Program, Nonphysician Education, Medical Education, Medical Director's Office, Housing, Social Service, Transportation; (ii) Ancillary Services - Laboratory Services, Electrocardiology, Electroencephalogy, Radiology, Inhalation Therapy, Podiatry, Dental, Psychiatric, Physical Therapy, Occupational Therapy, Speech/Hearing Therapy, Pharmacy, Central Services Supply, Medical Staff Services provided by licensed or certified professionals including and without limitation Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistant; and (iii) Program Services - Residential Health Care Facility, Pediatric, Traumatic Brain Injury (TBI), Autoimmune Deficiency Syndrome (AIDS), Long Term Ventilator, Respite, Behavioral Intervention, Neurodegenerative, Adult Care Facility, Intermediate Care Facilities, Independent Living, Outpatient Clinics, Adult Day Health Care, Home Health Care, Meals on Wheels, Barber & Beauty Shop, and Other similar program services that directly address the physical conditions of residents. Direct resident care does not include, at a minimum and without limitation, administrative costs (other than nurse administration), capital costs, debt service, taxes (other than sales taxes or payroll taxes), capital depreciation, rent and leases, and fiscal services.

(d) "Resident-facing staffing" shall include all staffing expenses in the ancillary and program services categories on exhibit h of the residential health care reports as in effect on February fifteenth, two thousand twenty-one.

(e) "Cost Report" shall mean the annual financial and statistical report submitted to the department pursuant to sections two thousand eight hundred five-e and two thousand eight hundred eight-b of this article, and regulations promulgated pursuant thereto, which includes the residential health care facility's revenues, expenses, assets, liabilities and statistical information.

3. For the purposes of this section, residential health care facilities shall not include (a) facilities that are authorized by the department to primarily care for medically fragile children, people with HIV/AIDS, persons requiring behavioral intervention, persons requiring neurodegenerative services, and other specialized populations that the commissioner deems appropriate to exclude; and (b) continuing care retirement communities licensed pursuant to article forty-six or forty six-a of this chapter.

4. The commissioner may waive the requirements of this section on a case-by-case basis with respect to a nursing home that demonstrates to the commissioner's satisfaction that it experienced unexpected or exceptional circumstances that prevented compliance. The commissioner may also exclude from revenues and expenses, on a case-by-case basis,

extraordinary revenues and capital expenses, incurred due to a natural disaster or other circumstances set forth by the commissioner in regulation. At least thirty days before any action by the commissioner under this subdivision, the commissioner shall transmit the proposed action to the state office of the long-term care ombudsman and the chairs of the senate and assembly health committees, and post it on the department's website.

5. The commissioner shall issue regulations, seek amendments to the state plan for medical assistance, seek waivers from the federal Centers for Medicare and Medicaid Services, and take such other actions as reasonably necessary to implement this section.

6. The commissioner shall, if necessary, update reporting forms completed by residential health care facilities under section twenty-eight hundred five-e of this article to include information to ensure all items referred to in this section and organize such information consistent with the terms of this section.

§ 2. Severability. If any provision of this act, or any application of any provision of this act, is held to be invalid, that shall not affect the validity or effectiveness of any other provision of this act or any other application of any provision of this act.

§ 3. This act shall take effect immediately.

PART HH

Section 1. Subdivision 3 of section 450 of the executive law, as added by chapter 588 of the laws of 1981, is amended to read as follows:

3. (a) The [~~membership of the developmental disabilities planning council shall at all times include representatives of the principal state agencies, higher education training facilities,~~] following people shall serve as ex officio members of the council:

(i) the head of any state agency that administers funds provided under federal laws related to individuals with disabilities, or such person's designee;

(ii) the head of any university center for excellence in developmental disabilities, or such person's designee; and

(iii) the head of the state's protection and advocacy system, or such person's designee.

(b) The membership of the developmental disabilities planning council shall also include local agencies, and non-governmental agencies and groups concerned with services to persons with developmental disabilities in New York state[~~;~~].

[~~(b)~~] (c) At least [~~one-half~~] sixty percent of the [~~membership~~] members appointed by the governor shall consist of[~~:~~

~~(i)~~] developmentally disabled persons or their parents or guardians or of immediate relatives or guardians of persons with [~~mentally impairing~~] developmental disabilities[~~;~~].

[~~(ii) these~~] (i) These members may not be employees of a state agency receiving funds or providing services under the federal developmental disabilities assistance act or have a managerial, proprietary or controlling interest in an entity which receives funds or provides services under such act,

[~~(iii) at~~] (ii) At least one-third of these members shall be developmentally disabled,

[~~(iv) at~~] (iii) At least one-third of these members shall be immediate relatives or guardians of persons with [~~mentally impairing~~] developmental disabilities, and

[~~(v) at~~] (iv) At least one member shall be an immediate relative or guardian of an institutionalized developmentally disabled person[~~;~~

~~(c) The membership may include some or all of the members of the advisory council on mental retardation and developmental disabilities~~].

§ 2. This act shall take effect immediately.

PART II

Section 1. Paragraph (d-2) of subdivision 3 of section 364-j of the social services law, as amended by section 10 of part B of chapter 57 of the laws of 2018, is amended to read as follows:

(d-2) Services provided pursuant to waivers, granted pursuant to subsection (c) of section 1915 of the federal social security act, to persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services, shall not be provided to medical assistance recipients through managed care programs until at least January first, two thousand [~~twenty-two~~] twenty-six.

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

PART JJ

Section 1. Subdivision 3 of section 364-j of the social services law is amended by adding a new paragraph (d-3) 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. 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, 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 KK

Section 1. Section 4 of chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, as amended by section 17 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 4. This act shall take effect on the sixtieth day after it shall have become a law; provided, however, that this act shall remain in effect until July 1, [~~2021~~] 2022 when upon such date the provisions of this act shall expire and be deemed repealed; provided, further, that a displaced worker shall be eligible for continuation assistance retroactive to July 1, 2004.

§ 2. This act shall take effect immediately.

PART LL

Section 1. Subparagraph (vi) of paragraph (b) of subdivision 4-a of section 365-f of the social services law, as amended by section 4 of part G of chapter 57 of the laws of 2019, is amended to read as follows:

(vi) the commissioner is authorized to either reoffer contracts [~~under the same terms of this subdivision, if determined necessary by the commissioner~~] or utilize the previous offer, to ensure that all provisions of this section are met.

§ 2. Subdivision 4-a of section 365-f of the social services law is amended by adding three new paragraphs (b-1), (b-2) and (b-3) to read as follows:

(b-1) Following the initial selection of contractors pursuant to this subdivision the commissioner is instructed to survey for information relating to the additional selection criteria under this paragraph and paragraph (b-2) of this subdivision, in writing in a manner determined by the commissioner, from all applicants that were qualified by the commissioner as meeting minimum requirements of the procurement process described in paragraph (b) of this subdivision including those that were not awarded contracts under that process:

(i) whether the applicant is formed as a charitable corporation under article two of the not-for-profit corporation law or authorized as a foreign corporation under article thirteen of the not-for-profit corporation law;

(ii) was the applicant performing administrative services as a fiscal intermediary prior to January first, two thousand twelve and has it continuously provided such services for eligible individuals pursuant to this section since that date;

(iii) the address the applicant listed as its primary mailing address on its most recently filed state corporate tax return or its Federal Return of Organization Exempt From Income Tax form (form 990);

(iv) whether the applicant is currently authorized, funded, approved or certified to deliver state plan or home and community-based waiver supports and services to individuals with intellectual and developmental disabilities by the office for people with developmental disabilities;

(v) whether the applicant has historically provided fiscal intermediary administrative services to racial and ethnic minority residents or new Americans, as defined in section ninety-four-b of the executive law, in such consumers' primary language, as evidenced by information and materials provided to consumers in the consumers' primary language or languages; and

(vi) whether the applicant is verified as a minority or woman-owned business enterprise pursuant to section three hundred fourteen of the executive law.

(b-2) The commissioner shall give applicants thirty days to respond to the survey. The failure of any applicants to respond to the survey and provide the information sought within such thirty-day period shall disqualify such applicants from consideration of any additional awards. Following receipt of the survey responses from applicants, the commissioner shall make awards to qualified applicants that previously submitted applications, in addition to any awards already announced, as may be necessary to ensure the commissioner has made awards as follows:

(i) the commissioner shall make awards to one or two additional applicants, to the extent that such applications were received, that are located in each county with a population of more than two hundred thousand but less than five hundred thousand as evidenced by the primary mailing address from the information surveyed under subparagraph (iii) of paragraph (b-1) of this subdivision.

(ii) the commissioner shall make awards to one or two additional applicants, to the extent that such applications were received, that are located in each county with a population of five hundred thousand or more as evidenced by the primary mailing address from the information surveyed under subparagraph (iii) of paragraph (b-1) of this subdivision.

(iii) to provide geographic distribution that would ensure access in different regions of the state the commissioner shall make awards to at least two additional applicants, to the extent that such applications were received, that are currently authorized, funded, approved or certified to deliver state plan or home and community-based waiver supports and services to individuals with intellectual and developmental disabilities by the office for people with developmental disabilities and meet the following criteria:

(A) are organized as a not-for-profit corporation pursuant to article two of the not-for-profit corporation law or authorized as a foreign corporation under article thirteen of the not-for-profit corporation law; or

(B) have been performing administrative services as fiscal intermediaries prior to January first, two thousand twelve and have been continuously providing such services for eligible individuals pursuant to this section since that date.

(iv) to provide geographic distribution that would ensure access in different regions of the state the commissioner shall make awards to at least two additional applicants, to the extent that such applications were received, that serve racial and ethnic minority residents, religious minority residents, or new Americans in those consumers' primary language, as evidenced by information and materials provided to consumers in the consumers' primary language or languages and meet the following criteria:

(A) are organized as a not-for-profit corporation pursuant to the not-for-profit corporation law or authorized as a foreign corporation under article thirteen of the not-for-profit corporation law; or

(B) have been performing administrative services as fiscal intermediaries prior to January first, two thousand twelve and have been continuously providing such services for eligible individuals pursuant to this section since that date.

(v) to provide geographic distribution that would ensure access in different regions of the state the commissioner shall make awards to at least two additional applicants, to the extent that such applications were received, that have been verified as a minority or woman-owned business enterprise pursuant to section three hundred fourteen of the executive law.

(vi) Notwithstanding the requirements of this paragraph, the commissioner may only make awards to the extent that applicants that meet the prescribed criteria, as evidenced by the results of the survey required under paragraph (b-1) of this subdivision, submitted qualifying applications and the commissioner shall not be required to make awards where no applicant meets the prescribed criteria.

(b-3) In awarding any new contracts pursuant to paragraph (b-2) of this subdivision, the commissioner shall not rescore the offers based on the results of the survey required under paragraph (b-1) of this subdivision, but shall award such contracts to the next highest scoring applicant or applicants that meet the criteria under paragraph (b-2) of this subdivision.

§ 3. Paragraphs (d) and (e) of subdivision 4-d of section 365-f of the social services law are relettered paragraphs (e) and (f) and a new paragraph (d) is added to read as follows:

(d) where a fiscal intermediary is acquired by, merges with, sells assets to, or engages in a transaction of a similar nature with a fiscal intermediary that was awarded a contract pursuant to subdivision four-a of this section, all the provisions of this subdivision shall apply. In providing notice under subparagraph (i) of paragraph (a) of this subdivision, the fiscal intermediary may inform the notice recipient of the applicable transaction and, if applicable, the ability of the consumer to remain with the awarded fiscal intermediary in accordance with any guidance issued by the commissioner.

§ 4. This act shall take effect immediately.

PART MM

Section 1. The public health law is amended by adding a new section 2808-e to read as follows:

§ 2808-e. Residential health care for children with medical fragility in transition to young adults and young adults with medical fragility demonstration program. 1. Notwithstanding any law, rule, or regulation to the contrary, the commissioner shall, within amounts appropriated and subject to the availability of federal financial participation, establish a demonstration program for two eligible pediatric residential health care facilities, as defined in paragraph (d) of subdivision two of this section, to construct a new facility or repurpose part of an existing facility to operate as a young adult residential health care facility for the purpose of improving the quality of care for young adults with medical fragility.

2. For purposes of this section:

(a) "children with medical fragility" shall mean children up to twenty-one years of age who have a chronic debilitating condition or conditions, are at risk of hospitalization, are technology-dependent for life or health sustaining functions, require complex medication regimens or medical interventions to maintain or to improve their health status, and/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.

(b) "young adults with medical fragility" shall mean individuals who meet the definition of children with medical fragility, but for the fact such individuals are aged between eighteen and thirty-five years old.

(c) "pediatric residential health care facility" shall mean a residential health care facility or discrete unit of a residential health care facility providing services to children under the age of twenty-one.

(d) "eligible pediatric residential health care facilities" shall mean pediatric health care facilities that meet the following eligibility criteria for the demonstration program set forth in subdivision one of this section: (i) has over one hundred and sixty licensed pediatric beds; or (ii) is currently licensed for pediatric beds pursuant to this article, is co-operated by a system of hospitals licensed pursuant to this article, and such hospitals qualify for funds pursuant to a vital access provider assurance program or a value based payment incentive program, as administered by the department in accordance with all requirements set forth in the state's federal 1115 Medicaid waiver standard terms and conditions.

3. Notwithstanding any law, rule, or regulation to the contrary, any child with medical fragility who has resided for at least thirty consecutive days in an eligible pediatric residential health care facility and who has reached the age of twenty-one while a resident, may continue residing at such eligible pediatric residential health care facility and receiving such services from the facility, provided that such young adult with medical fragility remains eligible for nursing home care, and provided further that the eligible pediatric residential health care facility has prepared, applied for, and submitted to the commissioner, a proposal for a new residential health care facility for the provision of extensive nursing, medical, psychological and counseling support services to young adults with medical fragility in accordance with subdivision four of this section. A young adult with medical fragility may remain in such eligible pediatric residential health care facility until such time that the young adult with medical fragility attains the age of thirty-five years or the young adult residential health care facility is constructed and becomes operational, whichever is sooner.

4. Upon receipt of a certificate of need application from an eligible pediatric residential health care facility selected by the commissioner for the demonstration program authorized under this section, the commissioner is authorized to approve, with the written approval of the public health and health planning council pursuant to section twenty-eight hundred two of this article, the construction of a new residential health care facility to be constructed and operated on a parcel of land within the same county as that of eligible pediatric residential health care facility that is proposing such new facility and over which it will have site control, or the repurposing of a portion of a residential health care facility that is currently serving geriatric residents or those with similar needs for the provision of nursing, medical, psychological and counseling support services appropriate to the needs of nursing home-eligible young adults with medical fragility, referred to herein below as a young adult facility, provided that the established operator of such eligible pediatric residential health care facility proposing the young adult facility is in good standing and possesses at least thirty years' prior experience operating as a pediatric residential health care facility in the state or more than thirty years' experience serving medically fragile pediatric patients, and provided further that such facility qualifies for the demonstration program set forth in subdivision one of this section.

5. A young adult facility established pursuant to subdivision four of this section may admit, from the community-at-large or upon referral from an unrelated facility, young adults with medical fragility who prior to reaching age twenty-one were children with medical fragility, and who are eligible for nursing home care and in need of extensive nursing, medical, psychological and counseling support services, provided that the young adult facility, to promote continuity of care, undertakes to provide priority admission to young adults with medical fragility transitioning from the pediatric residential health care facility or unit operated by the entity that proposed the young adult facility and ensure sufficient capacity to admit such young adults as they approach or attain twenty-one years of age.

6. (a) For inpatient services provided to any young adults with medical fragility eligible for medical assistance pursuant to title eleven of article five of the social services law residing at any eligible pediatric residential health care facility as authorized in subdivision three of this section, the commissioner shall establish the operat-

ing component of rates of reimbursement appropriate for young adults with medical fragility residing at a pediatric residential health care facility, to apply to such young adults twenty-one years of age or older. Such methodology shall take into account the methodology used to establish the operating component of the rates pursuant to section twenty eight hundred eight of this article for pediatric residential health care facilities with an increase or decrease adjustment as appropriate to account for any discrete expenses associated with caring for young adults with medical fragility, including addressing their distinct needs as young adults for psychological and counseling support services.

(b) For inpatient services provided to any young adults with medical fragility eligible for medical assistance pursuant to title eleven of article five of the social services law at any young adult facility as authorized in subdivision four of this section, the commissioner shall establish the operating component of rates of reimbursement appropriate for young adults with medical fragility. Such methodology shall take into account the methodology used to establish the operating component of the rates pursuant to section twenty eight hundred eight of this article for pediatric residential health care facilities with an increase or decrease adjustment as appropriate to account for any discrete expenses associated with caring for young adults with medical fragility, including addressing their distinct needs as young adults for psychological and counseling support services.

7. The commissioner shall have authority to waive any rule or regulation to effectuate the demonstration program authorized pursuant to subdivision one of this section.

§ 2. Within one year of the expiration of the demonstration program established pursuant to section twenty-eight hundred eight-e of the public health law, the department of health shall submit a report to the governor, the temporary president of the senate, and the speaker of the assembly regarding the results of the demonstration program. Such report shall include a recommendation regarding the expansion of the demonstration program and other metrics to define the need for and cost of services for the population of young adults with medical fragility, as determined by the commissioner of health.

§ 3. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided however, that section one of this act shall expire and be deemed repealed two years after such effective date; and provided further, that section two of this act shall expire and be deemed repealed three years after such effective date.

PART NN

Section 1. Subdivision 14 of section 366 of the social services law, as amended by section 71 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

14. The commissioner of health may make any available amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or, if an amendment is not possible, develop and submit an application for any waiver or approval under the federal social security act that may be necessary to disregard or exempt an amount of income, for the purpose of assisting with housing costs, for individuals receiving coverage of nursing facility services under this title, other than short-term rehabilitation services, and for individuals in receipt of medical assistance while in an adult home, as defined in subdivision twenty-five of section two of this chapter, who:

are (i) discharged to the community; and (ii) if eligible, enrolled **or required to enroll and have initiated the process of enrolling** in a plan certified pursuant to section forty-four hundred three-f of the public health law; and (iii) do not meet the criteria to be considered an "institutionalized spouse" for purposes of section three hundred sixty-six-c of this title.

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

PART OO

Section 1. Section 10 of part KKK of chapter 56 of the laws of 2020 amending the social services law and other laws relating to managed care encounter data, authorizing electronic notifications, and establishing regional demonstration projects, is amended to read as follows:

§ 10. Contingent upon the availability of federal financial participation or other federal authorization from the centers of medicare and medicaid services, the commissioner of health, in consultation with the superintendent of the department of financial services, is authorized to implement one or more five-year regional demonstration programs that would be designed to improve health outcomes and reduce costs, using a value based model that pays providers an actuarially sound global, prepaid and fully capitated amount for individuals in the designated region who are enrolled in the state's plan for medical assistance established pursuant to title XIX, or any successor title, of the federal social security act; the Medicare program established pursuant to title XVIII, or any successor title, of the federal social security act; and insurers, corporations, and health care plans authorized pursuant to the insurance law or public health law. The demonstration program may offer funding and incentives designed to improve health outcomes for attributed individual beneficiaries designed to improve health outcomes, develop necessary infrastructure and systems; and connect individuals to community based organizations that address the social determinants of health. **At least one regional demonstration program shall be in the western, central, southern tier, or capital regions of the state.** Notwithstanding any provision of law to the contrary, the commissioner or the superintendent of the department of financial services may waive any regulatory requirements as are necessary to implement the demonstration program; provided however, that regulations pertaining to patient safety, patient autonomy, patient privacy, patient rights, due process, scope of practice, professional licensure, environmental protections, provider reimbursement methodologies, or occupational standards and employee rights may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Participation in such program shall be voluntary. One year after this section shall take effect and annually thereafter the commissioner of health shall provide a report detailing the activities and outcomes of such program, including any regulatory requirements that are waived, to the speaker of the assembly and the temporary president of the senate.

§ 2. This act shall take effect immediately.

PART PP

Section 1. Subdivision 8 of section 268-a of the public health law, as added by section 2 of part T of chapter 57 of the laws of 2019, is amended to read as follows:

8. "Insurance affordability program" means Medicaid, child health plus, the basic health program, post-partum extended coverage and any other health insurance subsidy program designated as such by the commissioner.

§ 2. The social services law is amended by adding a new section 369-hh to read as follows:

§ 369-hh. Extended post-partum insurance coverage. 1. Definitions. For purposes of this section:

(a) "Qualified individual" shall mean a person who is eligible to enroll in a qualified health plan according to the definition found in subdivision nine of section two hundred sixty-eight-a of the public health law.

(b) "Qualified health plan" shall mean a health plan as defined in subdivision seven of section two hundred sixty-eight-a of the public health law.

(c) "Silver level qualified health plan" means a qualified health plan that has an actuarial value in accordance with the levels established by the marketplace for qualified individuals with an income between two hundred and two hundred fifty percent of the federal poverty level.

(d) "Advanced premium tax credits" means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to qualified individuals enrolled in a qualified health plan through the New York state of health, the official health plan marketplace in accordance with section 1412(a) of the Affordable Care Act, 42 U.S.C. § 18082(c)(2).

(e) "Health care services" means 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 purposes of defining such benefits.

2. Authorization. The commissioner of health is authorized, with the approval of the director of the budget, to establish a program for the subsidization of extended post-partum insurance coverage to the individuals eligible under this section.

3. Eligibility. (a) A person is eligible to receive coverage for health care services pursuant to this title if they:

(i) Are a qualified individual pursuant to subdivision ten of section two hundred sixty-eight-a of the public health law;

(ii) Were eligible for medical assistance following a pregnancy pursuant to subparagraph one of paragraph (b) of subdivision four of section three hundred sixty-six of this article; and

(iii) Have income which exceeds two hundred percent, but does not exceed two hundred and twenty-three percent, of the 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.

(b) A person eligible under this subdivision remains eligible until the end of the twelfth month following the end of a pregnancy.

4. Enrollment. (a) On the first day of the month following disenrollment from medical assistance, pursuant to subparagraph one of paragraph (b) of subdivision four of section three hundred sixty-six of this article, persons eligible under this section will be enrolled in a state-subsidized silver level qualified health plan.

(b) Enrollment shall be subject to eligible individuals under this section applying for and enrolling with the maximum advance premium tax credit amount available to them.

5. Premiums. The state shall pay an eligible individual's remaining premium obligation directly to their qualified health plan after applying the individual's maximum premium assistance amount, under section 1401(a) of the Patient Protection and Affordable Care Act, 26 U.S.C. § 36B(b)(2) and (3).

§ 3. This act shall take effect October 1, 2021. The commissioner of health shall immediately take all steps necessary and shall use best efforts to secure federal financial participation for eligible beneficiaries under title XIX of the social security act, for the purposes of this act, including the prompt submission of appropriate amendments to the title XIX state plan.

PART QQ

Section 1. The commissioner of health shall provide a report to the temporary president of the senate, the speaker of the assembly, and the chairs of the senate and assembly health committees by December 31, 2021 detailing the statutes, rules, and regulations, as well as other limitations or processes, that apply to and govern the calculation and payment of prescription drug dispensing fees to retail pharmacies by the state's medical assistance program, both within the Medicaid managed care and fee-for-service programs for the legislature to review, study, and better understand the information provided in such report.

§ 2. This act shall take effect immediately.

§ 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 QQ of this act shall be as specifically set forth in the last section of such Parts.