STATE OF NEW YORK

S. 8007--C A. 9007--C

SENATE - ASSEMBLY

January 19, 2022

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 the public health law, in relation to the implementation of the nurses across New York (NANY) program (Part A); intentionally omitted (Part B); to amend the public health law and the education law, in relation to allowing pharmacists to direct limited service laboratories and order and administer COVID-19 and influenza tests and modernizing nurse practitioners; to amend the education law, in relation to allowing for certain individuals to administer tests to determine the presence of COVID-19 or its antibodies or influenza virus in certain situations; to amend part D of chapter 56 of the laws of 2014, amending the education law relating to enacting the "nurse practitioners modernization act", in relation to the effectiveness thereof; and providing for the repeal of certain provisions upon the expiration thereof (Part C); intentionally omitted (Part D); to amend the public health law, in relation to increasing general public health work base grants for both full-service and partial-service counties and allow for local health departments to claim up to fifty percent of personnel service costs (Part E); intentionally omitted (Part F); intentionally omitted (Part G); to amend part H of 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 the

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

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cap on local Medicaid expenditures (Part H); to provide a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates (Part I); to amend the public health law, in relation to extending the statutory requirement to reweight and rebase acute hospital rates (Part J); to amend the public health law, in relation to the creation of a new statewide health care facility transformation program (Part K); intentionally omitted (Part L); to amend the public health law, in relation to the definition of revenue in the minimum spending statute for nursing homes and the rates of payment and rates of reimbursement for residential health care facilities, in relation to making a temporary payment to facilities in severe financial distress, and in relation to requiring certain percentages of revenue be spent on direct resident care and resident-facing staffing (Part M); intentionally omitted (Part N); to amend the social services law, in relation to private duty nursing services reimbursement for nurses servicing adult members; to amend the public health law, in relation to rates of payment for continuous nursing services for certain adults; and to amend part MM of chapter 56 of the laws of 2020 directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, in relation to directing the department of health to develop guidelines and standards for the use of tasking tools (Part O); to amend the social services law and the public health law, in relation to the essential plan and qualified health plans to contract with national cancer institute-designated cancer centers, where such centers agree to certain terms and conditions; and to require the department of health to select an independent contractor to generate a report that reviews and makes recommendations concerning the status of services offered by managed care organizations contracting with the state to manage services provided under the Medicaid program (Part P); intentionally omitted (Part Q); to amend the insurance law, in relation to requiring private insurance plans to cover abortion services without cost-sharing (Part R); intentionally omitted (Part S); intentionally omitted (Part T); intentionally omitted (Part U); to amend the public health law and the insurance law, in relation to reimbursement for commercial and Medicaid services provided via telehealth; and providing for the repeal of such provisions upon the expiration thereof (Part V); to amend the social services law, in relation to eliminating unnecessary requirements from the utilization threshold program (Part W); intentionally omitted (Part X); to amend the domestic relations law, in relation to marriage certificates (Part Y); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending the effectiveness of certain provisions thereof; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part Z); to amend the financial services law, the insurance law and the public health law, in relation to clarifying provisions regarding emergency medical

services and surprise bills; and to repeal certain provisions of the financial services law relating thereto (Subpart A); to amend the insurance law and the public health law, in relation the the federal no surprises act (Subpart B); and to amend the insurance law and the public health law, in relation to administrative simplification (Subpart C) (Part AA); intentionally omitted (Part BB); to amend the social services law, the executive law and the public health law, in relation to extending various provisions relating to health and mental hygiene; to amend part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend part E of chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness thereof; to amend part II of chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, in relation to the effectiveness thereof; to amend chapter 74 of the laws of 2020, relating to directing the department of health to convene a work group on rare diseases, in relation to the effectiveness thereof; and to amend chapter 414 of the laws of 2018, creating the radon task force, in relation to the effectiveness thereof (Part CC); establishing a cost of living adjustment for designated human services programs (Part DD); to amend the mental hygiene law, in relation to a 9-8-8 suicide prevention and behavioral health crisis hotline system (Part EE); to amend the social services law, in relation to reinvesting savings recouped from behavioral health transition into managed care back into behavioral health services (Part FF); to amend part H of chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof (Part GG); intentionally omitted (Part HH); to amend the mental hygiene law, in relation to community residences for addiction (Part II); intentionally omitted (Part JJ); intentionally omitted (Part KK); to amend chapter 56 of the laws of 2013 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and referencing the office of addiction services and supports; to amend part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services referencing the office of addiction services and supports and in relation to the effectiveness thereof (Part LL); intentionally omitted (Part MM); to amend the mental hygiene law, in relation to rental and mortgage payments for the mentally ill (Part NN); to amend part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental

disabilities and/or chemical dependence, in relation to the effectiveness thereof (Part OO); to amend the social services law, in relation to the process for the selection of fiscal intermediary services contractors for the consumer directed personal assistance program; to repeal subdivision 4 and paragraphs (b-2) and (b-3) of subdivision 4-a of section 365-f of the social services law relating to certain surveys and to the award of contracts (Part PP); to amend the social services law, part C of chapter 57 of the laws of 2018, amending the social services law and the public health law relating to health homes and penalties for managed care providers, and part MM of chapter 56 of the laws of 2020, directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, in relation to prohibiting the extension of certain contracts (Part QQ); to amend the tax law, in relation to the deposit of certain revenues from taxes into the New York state agency trust fund, distressed provider assistance account; to amend part ZZ of chapter 56 of the laws of 2020 amending the tax law and the social services law relating to certain Medicaid management, in relation to the effectiveness thereof; and to repeal certain provisions of the tax law relating to financially distressed hospitals (Part RR); directing the department of health to conduct a study within Kings county to determine ways to improve access to health services and facilities (Part SS); and to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws, relating to general hospital inpatient reimbursement for annual rates, in relation to supplemental Medicaid managed care payments (Part TT)

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

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

PART A

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

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

§ 2807-aa. Nurse loan repayment program. 1.(a) Monies shall be made available, subject to appropriations, for purposes of loan repayment awards in accordance with the provisions of this section for registered professional nurses licensed to practice under section sixty-nine hundred five of the education law and licensed practical nurses licensed under section sixty-nine hundred six of the education law. Notwithstand-

ing sections one hundred twelve and one hundred sixty-three of the state finance law and sections one hundred forty-two and one hundred forty-three of the economic development law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposals.

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

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

(iii) Nurses shall be eligible for a loan repayment award to be determined by the commissioner over a three-year period distributed as follows: thirty percent of total award for the first year; thirty percent of total award for the second year; and any unpaid balance of the total award not to exceed the maximum award amount for the third year.

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

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

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

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

ods in a manner determined by the commissioner for the purpose set forth in this section.

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

PART B

Intentionally Omitted

PART C

Section 1. Subdivision 6 of section 571 of the public health law, as amended by chapter 444 of the laws of 2013, is amended to read as follows:

6. "Qualified health care professional" means a physician, dentist, podiatrist, optometrist performing a clinical laboratory test that does not use an invasive modality as defined in section seventy-one hundred one of the education law, pharmacist administering COVID-19 and influenza tests pursuant to subdivision seven of section sixty-eight hundred one of the education law, physician assistant, specialist assistant, nurse practitioner, or midwife, who is licensed and registered with the state education department.

§ 2. Section 6801 of the education law, is amended by adding a new subdivision 7 to read as follows:

7. A licensed pharmacist is a qualified health care professional under section five hundred seventy-one of the public health law for the purposes of directing a limited service laboratory and ordering and administering COVID-19 and influenza tests authorized by the Food and Drug Administration (FDA), subject to certificate of waiver requirements established pursuant to the federal clinical laboratory improvement act of nineteen hundred eighty-eight.

§ 3. Subparagraph (iv) of paragraph (a) of subdivision 3 of section 6902 of the education law, as amended by section 2 of part D of chapter 56 of the laws of 2014, is amended to read as follows:

(iv) The practice protocol shall reflect current accepted medical and nursing practice[~~. The protocols shall be filed with the department within ninety days of the commencement of the practice~~] and may be updated periodically. The commissioner shall make regulations establishing the procedure for the review of protocols and the disposition of any issues arising from such review.

§ 4. Paragraph (b) of subdivision 3 of section 6902 of the education law, as added by section 2 of part D of chapter 56 of the laws of 2014, is amended to read as follows:

(b) Notwithstanding subparagraph (i) of paragraph (a) of this subdivision, a nurse practitioner, certified under section sixty-nine hundred ten of this article and practicing for more than three thousand six hundred hours [~~may comply with this paragraph in lieu of complying~~] shall not be required to comply with the requirements of paragraph (a) of this subdivision relating to collaboration with a physician, a written practice agreement and written practice protocols. [~~A nurse practitioner complying with this paragraph shall have collaborative relationships with one or more licensed physicians qualified to collaborate in the specialty involved or a hospital, licensed under article twenty-eight of the public health law, that provides services through licensed~~

~~physicians qualified to collaborate in the specialty involved and having privileges at such institution. As evidence that the nurse practitioner maintains collaborative relationships, the nurse practitioner shall complete and maintain a form, created by the department, to which the nurse practitioner shall attest, that describes such collaborative relationships. For purposes of this paragraph, "collaborative relationships" shall mean that the nurse practitioner shall communicate, whether in person, by telephone or through written (including electronic) means, with a licensed physician qualified to collaborate in the specialty involved or, in the case of a hospital, communicate with a licensed physician qualified to collaborate in the specialty involved and having privileges at such hospital, for the purposes of exchanging information, as needed, in order to provide comprehensive patient care and to make referrals as necessary. Such form shall also reflect the nurse practitioner's acknowledgement that if reasonable efforts to resolve any dispute that may arise with the collaborating physician or, in the case of a collaboration with a hospital, with a licensed physician qualified to collaborate in the specialty involved and having privileges at such hospital, about a patient's care are not successful, the recommendation of the physician shall prevail. Such form shall be updated as needed and may be subject to review by the department. The nurse practitioner shall maintain documentation that supports such collaborative relationships. Failure to comply with the requirements found in this paragraph by a nurse practitioner who is not complying with such provisions of paragraph (a) of this subdivision, shall be subject to professional misconduct provisions as set forth in article one hundred thirty of this title.~~]

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

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

§ 6. Subdivision 6 of section 6527 of the education law is amended by adding a new paragraph (h) to read as follows:

(h) administering tests to determine the presence of COVID-19 or its antibodies or influenza virus.

§ 7. Subdivision 4 of section 6909 of the education law is amended by adding a new paragraph (h) to read as follows:

(h) administering tests to determine the presence of COVID-19 or its antibodies or influenza virus.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, that sections one, two, three, four, six and seven of this act shall expire and be deemed repealed two years after it shall have become a law.

PART D

Intentionally Omitted

PART E

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

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

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

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

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

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

4. Moneys appropriated for the purposes of this article to a municipality may include reimbursement of a municipality's fringe benefits, including but not limited to employee retirement funds, health insurance and federal old age and survivor's insurance. However, costs submitted under an application for state aid must be consistent with a munici-

pality's documented fringe benefit costs and shall not exceed fifty per centum of the municipality's eligible personnel services.

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

PART F

Intentionally Omitted

PART G

Intentionally Omitted

PART H

Section 1. Subdivision 1 of section 91 of part H of 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 2 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

1. Notwithstanding any inconsistent provision of state law, rule or regulation to the contrary, subject to federal approval, the year to year rate of growth of department of health state funds Medicaid spending shall not exceed the [~~ten~~] five year rolling average of the [~~medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics,~~] Medicaid spending annual growth rate projections within the National Health Expenditure Accounts produced by the office of the actuary in the federal Centers for Medicare and Medicaid services for the preceding [~~ten~~] five years; provided, however, that for state fiscal year 2013-14 and for each fiscal year thereafter, the maximum allowable annual increase in the amount of department of health state funds Medicaid spending shall be calculated by multiplying the department of health state funds Medicaid spending for the previous year, minus the amount of any department of health state operations spending included therein, by such [~~ten~~] five year rolling average.

§ 2. 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 general hospital reimbursement for annual rates, as amended by section 1 of part A of chapter 57 of the laws of 2021, is amended to read as follows:

(a) For state fiscal years 2011-12 through [~~2021-22~~] 2023-24, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a quarterly basis, as reflected in 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.

§ 3. 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 general hospital reimbursement for annual rates, as amended by section 2 of part A of chapter 57 of the laws of 2021, is amended to read as follows:

5. The commissioner of health, in consultation with the director of budget, shall prepare a 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; **the methodology by which such projections are compiled or determined; and for periods following April 1, 2022, the projected savings or investment from the enacted budget that implemented the program or initiative, along with the actual or known savings or investment from such program or initiative;**

(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**, to the extent practicable,** 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~~]
(xxi) vital access provider assurance program;
(xxii) home care;
(xxiii) personal care, including consumer directed personal assistance program;
(xxiv) any programs that were instituted subsequent to the last report issued under this subdivision and not reported; 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 quarter and any anticipated material impacts for the quarter in which the report required under this subdivision is issued, as well as anticipated material impacts for the quarter subsequent to such report. **The report will also include, to the extent practicable, an appendix that will provide, including but not limited to: (1) the methodology by which projections for such material impacts are compiled or determined; (2) program trends, including enrollment actuals and projections; (3) detail on the anticipated spending outside of the Global Cap relating to DOH Medicaid; (4) detail on the anticipated and projected mental hygiene stabalization fund transfer; (5) the number of fiscal intermediaries contracted with the Department of Health; (6) links to the approved fee-for-service rates for general hospitals, inclusive of any rate appeals and rate adjustments; and (7) links to the approved fee-for-service rates of pharmaceutical drugs on the preferred drug list.**

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

PART I

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

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

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

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

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

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

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

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

PART J

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

(c) **1.** The base period reported costs and statistics used for rate-setting for operating cost components, including the weights assigned to diagnostic related groups, shall be updated no less frequently than every four years and the new base period shall be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on or after April first, two thousand fourteen, but no later than July first, two thousand fourteen**; and further provided that the updated base period subsequent to July first, two thousand eighteen shall begin on or after January first, two thousand twenty-four**.

2. In the event of a declaration of a federal public health emergency, as defined in 42 USC § 247d, or a state disaster emergency, as defined in section twenty of the executive law, that severely impacts general hospitals within the state, the department may exclude, for purposes of this paragraph, the audited reported costs and statistics during such declaration.

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

PART K

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

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

2. The commissioner shall enter into an agreement with the president of the dormitory authority of the state of New York pursuant to section sixteen hundred eighty-r of the public authorities law, which shall apply to this agreement, subject to the approval of the director of the division of the budget, for the purposes of the distribution and admin-

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

3. Notwithstanding subdivision two of this section or any inconsistent provision of law to the contrary, and upon approval of the director of the budget, the commissioner may, subject to the availability of lawful appropriation, award up to four hundred fifty million dollars of the funds made available pursuant to this section for unfunded project applications submitted in response to the request for application number 18406 issued by the department on September thirtieth, two thousand twenty-one pursuant to section twenty-eight hundred twenty-five-f of this article. Authorized amounts to be awarded pursuant to applications submitted in response to the request for application number 18406 shall be awarded no later than December thirty-first, two thousand twenty-two. Provided, however, that a minimum of:

(a) twenty-five million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as diagnostic and treatment centers licensed or granted an operating certificate under this chapter; independent practice associations or organizations; home care providers certified or licensed pursuant to article thirty-six of this chapter; and hospices licensed or granted an operating certificate pursuant to article forty of this chapter;

(b) twenty-five million dollars of total awarded funds shall be made to a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; alcohol and substance use disorder treatment clinics licensed or granted an operating certificate under article thirty-two of the mental hygiene law;

clinics licensed or granted an operating certificate under article sixteen of the mental hygiene law; and community-based programs funded under the office of mental health or the office of addiction services and supports or through local governmental units as defined under article forty-one of the mental hygiene law; and

(c) fifty million dollars of total awarded funds shall be made to residential health care facilities or adult care facilities licensed under title two of article seven of the social services law.

4. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, or any inconsistent provision of law to the contrary, up to two hundred million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request for proposal process, for grants to health care providers for purposes of modernization of an emergency department of regional significance. For purposes of this subdivision, an emergency department shall be considered to have regional significance if it: (a) serves as Level 1 trauma center with the highest volume in its region; (b) includes the capacity to segregate patients with communicable diseases, trauma or severe behavioral health issues from other patients in the emergency department; (c) provides training in emergency care and trauma care to residents from multiple hospitals in the region; and (d) serves a high proportion of Medicaid patients.

5. (a) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, or any inconsistent provision of law to the contrary, up to seven hundred fifty million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request for proposal process, for grants to health care providers, as defined in subdivision two of this section.

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

(c) Provided, however, that a minimum of:

(i) twenty-five million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as diagnostic and treatment centers licensed or granted an operating certificate pursuant to this chapter; independent practice associations or organizations; home care providers certified or licensed pursuant to article thirty-six of this chapter; and hospices licensed or granted an operating certificate pursuant to article forty of this chapter;

(ii) twenty-five million dollars of total awarded funds shall be made to a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; alcohol and substance use disorder treatment clinics licensed or granted an operating certificate under article thirty-two of the mental hygiene law; clinics licensed or granted an operating certificate under article sixteen of the mental hygiene law; and community-based programs funded under the office of mental health or the office of addiction services and supports or through local governmental units as defined under article forty-one of the mental hygiene law; and

(iii) twenty-five million dollars of total awarded funds shall be made to residential health care facilities or adult care facilities licensed under title two of article seven of the social services law.

6. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, or any inconsistent provision of law to the contrary, up to one hundred fifty million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request for proposal process, for technological and telehealth transformation projects.

7. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, or any inconsistent provision of law to the contrary, up to fifty million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or a request for proposal process, to residential and community-based alternatives to the traditional model of nursing home care.

8. Selection of awards made by the department pursuant to subdivisions three, four, five, six and seven of this section shall be contingent on an evaluation process acceptable to the commissioner and approved by the director of the division of the budget. Disbursement of awards may be contingent on the health care provider as defined in subdivision two of this section achieving certain process and performance metrics and milestones that are structured to ensure that the goals of the project are achieved.

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

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

PART L

Intentionally Omitted

PART M

Section 1. Paragraph (a) of subdivision 2 of section 2828 of the public health law, as added by section 1 of part GG of chapter 57 of the laws of 2021, is amended to read as follows:

(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:

(i) the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years;

(ii) funding received as reimbursement for the assessment under subparagraph (vi) of paragraph (b) of subdivision two of section twenty-eight hundred seven-d of this article, as reconciled pursuant to paragraph (c) of subdivision ten of section twenty-eight hundred seven-d of this article;

(iii) the capital per diem portion of the reimbursement rate for nursing homes that have an overall four- or five-star rating assigned pursuant to the inspection rating system of the U.S. Centers for Medicare and Medicaid Services (CMS rating), provided however that such exclusion shall not apply to any amount of the capital per diem portion of the reimbursement rate that is attributable to a capital expenditure made to a corporation, other entity, or individual, with a common or familial ownership to the operator or the facility as reported under subdivision one of section twenty-eight hundred three-x of this chapter; and

(iv) any grant funds from the federal government for reimbursement of COVID-19 pandemic-related expenses, including but not limited to funds received from the federal emergency management agency or health resources and services administration.

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

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

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

Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand [~~fifteen~~] twenty-two through March thirty-

first, two thousand [~~sixteen~~] twenty-three, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible [~~general hospitals~~] facilities in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services. Provided, however, the commissioner is authorized to make such a temporary adjustment or make such temporary lump sum payment only pursuant to criteria, an evaluation process, and transformation plan acceptable to the commissioner in consultation with the director of the division of the budget. The department shall publish on its website the criteria, evaluation process and guidance for transformation plans and notification of any award recipients.

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

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

(B) a federally designated critical access hospital;

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

(D) a residential health care facility;

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

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

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

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

§ 4. Paragraph (c) of subdivision 1 of section 2828 of the public health law, as added by section 1 of part GG of chapter 57 of the laws of 2021, is amended to read as follows:

(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, or for the year two thousand twenty-two, on a pro-rata basis for only that portion of the year during which the failure of a residential health care facility to spend a minimum of seventy percent of revenue on direct resident care, and forty percent of revenue on resident-facing staffing, may be held to be a violation of this chapter, 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.

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

PART N

Intentionally Omitted

PART O

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

2. Medically fragile children **and medically fragile adults**. (a) In addition, the commissioner shall further increase rates for private duty nursing services that are provided to medically fragile children to ensure the availability of such services to such children. **Furthermore, no later than sixty days after the effective date of the chapter of the laws of two thousand twenty-two that amended this subdivision, increased rates shall be extended for private duty nursing services provided to medically fragile adults.** In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children **and medically fragile adults** in a non-institutional setting as compared to an institutional setting. Medically fragile children shall, for the purposes of this subdivision, have the same meaning as in subdivision three-a of section thirty-six hundred fourteen of the public health law. **For purposes of this subdivision, "medically fragile adult" shall be defined as including but not limited to any individual who previously qualified as a medically fragile child but no longer meets the age requirement.** Such increased rates for services rendered to such children **and adults** may take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the private duty nursing service is provided, costs associated with the provision of private duty nursing services to medically fragile children **and medically fragile adults**, and the need for incentives to improve services and institute economies and such increased rates shall be payable only to those private duty nurses who can demonstrate, to the satisfaction of the department of health, satisfactory training and experience to provide services to such chil-

dren **and medically fragile adults**. Such increased rates shall be determined based on application of the case mix adjustment factor for AIDS home care program services rates as determined pursuant to applicable regulations of the department of health. The commissioner may promulgate regulations to implement the provisions of this subdivision.

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

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

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

private duty nursing services. The commissioner may promulgate regulations to implement the provisions of this paragraph.

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

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

3-a. Medically fragile children **and medically fragile adults**. Rates of payment for continuous nursing services for medically fragile children **and medically fragile adults** provided by a certified home health agency, a licensed home care services agency or a long term home health care program shall be established to ensure the availability of such services, whether provided by registered nurses or licensed practical nurses who are employed by or under contract with such agencies or programs, and shall be established at a rate that is at least equal to rates of payment for such services rendered to patients eligible for AIDS home care programs; provided, however, that a certified home health agency, a licensed home care services agency or a long term home health care program that receives such enhanced rates for continuous nursing services for medically fragile children **and medically fragile adults** shall use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide such services. In the case of services provided by certified home health agencies and long term home health care programs through contracts with licensed home care services agencies, rate increases received by such certified home health agencies and long term home health care programs pursuant to this subdivision shall be reflected in payments made to the registered nurses or licensed practical nurses employed by such licensed home care services agencies to render services to these children **and medically fragile adults**. In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children **and medically fragile adults** in a non-institutional setting as compared to an institutional setting. For the purposes of this subdivision, a medically fragile child shall mean a child who is at risk of hospitalization or institutionalization, including but not limited to children who are technologically-dependent for life or health-sustaining functions, require complex medication regimen or medical interventions to maintain or to improve their health status or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk, but who are capable of being cared for at home if provided with appropriate home care services, including but not limited to case

management services and continuous nursing services. The commissioner shall promulgate regulations to implement provisions of this subdivision and may also direct the providers specified in this subdivision to provide such additional information and in such form as the commissioner shall determine is reasonably necessary to implement the provisions of this subdivision.

§ 3. Section 21 of part MM of chapter 56 of the laws of 2020, directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, is amended to read as follows:

§ 21. The department of health shall develop[~~, directly or through procurement, and shall implement an evidenced based validated uniform task-based assessment tool no later than April 1, 2021,~~] **guidelines and standards in consultation with subject matter experts for the use of tasking tools** to assist managed care plans and local departments of social services to make appropriate and individualized determinations for utilization of home care services in accordance with applicable state and federal law and regulations, including the number of personal care services and consumer directed personal assistance hours of care each day[~~,~~] provided pursuant to the state's medical assistance program, and how Medicaid recipients' needs for assistance with activities of daily living can be met, such as through telehealth, provided that services rendered via telehealth meet equivalent quality and safety standards of services provided through non-electronic means, and other available alternatives, including family and social supports. [~~Notwithstanding the provisions of section 163 of the state finance law, or sections 142 and 143 of the economic development law, or any contrary provision of law, a contract may be entered without a competitive bid or request for proposal process if such contract is for the purpose of developing the evidence based validated uniform task-based assessment tool described in this section, provided that:~~

~~(a) The department of health shall post on its website, for a period of no less than 30 days:~~

~~(i) A description of the evidence based validated uniform task-based assessment tool to be developed pursuant to the contract;~~

~~(ii) The criteria for contractor selection;~~

~~(iii) The period of time during which a prospective contractor may seek to be selected by the department of health, which shall be no less than 30 days after such information is first posted on the website; and~~

~~(iv) The manner by which a prospective contractor may submit a proposal for selection, which may include submission by electronic means;~~

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

~~(c) The commissioner of health shall select such contractor that is best suited to serve the purposes of this section and the needs of recipients; and~~

~~(d) All decisions made and approaches taken pursuant to this section shall be documented in a procurement record as defined in section one hundred sixty-three of the state finance law.~~]

§ 4. 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.

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

PART P

Section 1. Notwithstanding sections 112 and 163 of the state finance law, the department of health shall select an independent contractor to generate a report that reviews and makes recommendations concerning the status of services offered by managed care organizations contracting with the state to manage services provided under the Medicaid program. Such report shall be provided to the governor, the temporary president of the senate and the speaker of the assembly no later than October 31, 2022, and shall be for the purpose of informing the development of a plan to reform the delivery of services offered by managed care organizations in the Medicaid program. The report shall include the following: 1. A market assessment of the managed care organizations offering products in each market, including the appropriate number of managed care organizations to each region to address member needs; 2. Analysis of areas of potential improvements or challenges as they relate to healthcare access, delivery, outcomes, administrative costs, efficiencies and oversight that may result from competitive procurement; 3. Cost savings analysis that may result from a competitive procurement, if any; 4. The current approach for addressing Person Centered care for people with behavioral health needs enrolled with Medicaid managed care plans, including but not limited to special needs managed care organizations authorized to offer Health and Recovery Plans (HARPs) and the integration of those benefits with Mainstream Medicaid Managed Care (MMMC); 5. Provider network access that may result from competitively procuring plans in each region and potential improvements in standards governing network adequacy; 6. Managed care enrollee service disruptions that may result from competitively procuring managed care plans in each region; 7. Impacts to providers that contract or are affiliated with Medicaid managed care organizations that may result from a competitive procurement; 8. An evaluation of new performance standards or requirements that could be imposed upon Medicaid managed care organizations that participate in the managed care program pursuant to a contract with the department of health; and 9. An assessment of current mechanisms for enforcement of performance requirements, including but not limited to oversight of Medicaid managed care organizations and penalties.

§ 2. Subparagraphs (v) and (vi) of paragraph (b) of subdivision 1 of section 268-d of the public health law, as added by section 2 of part T of chapter 57 of the laws of 2019, are amended to read as follows:

(v) meets standards specified and determined by the Marketplace, provided that the standards do not conflict with or prevent the application of federal requirements; [~~and~~]

(vi) **contracts with any national cancer institute-designated cancer center licensed by the department within the health plan's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to enrollees in all health plans offering coverage through the Marketplace in such cancer center's service area under the**

prevailing terms and conditions that the plan requires of other similar providers to be included in the plan's provider network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services; and

(vii) complies with the insurance law and this chapter requirements applicable to health insurance issued in this state and any regulations promulgated pursuant thereto that do not conflict with or prevent the application of federal requirements; and

§ 3. Subdivision 4 of section 364-j of the social services law is amended by adding a new paragraph (w) to read as follows:

(w) A managed care provider shall provide or arrange, directly or indirectly, including by referral, for access to and coverage of services provided by any national cancer institute-designated cancer center licensed by the department of health within the managed care provider's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to participants in all managed care providers offering coverage to medical assistance recipients in such cancer center's service area under the prevailing terms and conditions that the managed care provider requires of other similar providers to be included in the managed care provider's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services.

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

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, and shall include coverage of and access to the services of any national cancer institute-designated cancer center licensed by the department of health within the service area of the approved organization that is willing to agree to provide cancer-related inpatient, outpatient and medical services to all enrollees in approved organizations' plans in such cancer center's service area under the prevailing terms and conditions that the approved organization requires of other similar providers to be included in the approved organization's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services; and (ii) dental and vision services as defined by the commissioner;

§ 5. Severability. If any clause, sentence, paragraph, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid and after exhaustion of all further judicial review, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this act directly involved in the controversy in which the judgment shall have been rendered.

§ 6. Sections one and five of this act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022. Sections two, three, and four of this act shall take

effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all coverage or policies issued or renewed on or after such effective date and shall expire and be deemed repealed five years after such date; provided, however, that the amendments to section 364-j of the social services law made by section three of this act, and the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by section four of this act shall not affect the repeal of such sections or such paragraph and shall be deemed repealed therewith.

PART Q

Intentionally Omitted

PART R

Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 36 to read as follows:

(36) (A) Every policy which provides hospital, surgical, or medical coverage and which offers maternity coverage pursuant to paragraph ten of this subsection shall also provide coverage for abortion services for an enrollee.

(B) Coverage for abortion shall not be subject to annual deductibles or coinsurance, including co-payments, unless the policy is a high deductible health plan as defined in section 223(c)(2) of the internal revenue code of 1986, in which case coverage for abortion may be subject to the plan's annual deductible.

§ 2. Subsection (k) of section 3221 of the insurance law is amended by adding a new paragraph 22 to read as follows:

(22) (A) Every policy which provides hospital, surgical, or medical coverage and which offers maternity care coverage pursuant to paragraph five of this subsection shall also provide coverage for abortion services for an enrollee.

(B) Coverage for abortion shall not be subject to annual deductibles or coinsurance, including co-payments, unless the policy is a high deductible health plan as defined in section 223(c)(2) of the internal revenue code of 1986, in which case coverage for abortion may be subject to the plan's annual deductible.

(C) Notwithstanding any other provision, a group policy that provides hospital, surgical, or medical expense coverage delivered or issued for delivery in this state to a religious employer, as defined in item one of subparagraph (E) of paragraph sixteen of subsection (l) of this section, may exclude coverage for abortion only if the insurer:

(i) obtains an annual certification from the group policyholder that the policyholder is a religious employer and that the religious employer requests a policy without coverage for abortion;

(ii) issues a rider to each certificate holder at no premium to be charged to the certificate holder or religious employer for the rider, that provides coverage for abortion subject to the same rules as would have been applied to the same category of treatment in the policy issued to the religious employer. The rider shall clearly and conspicuously specify that the religious employer does not administer abortion benefits, but that the insurer is issuing a rider for coverage of abortion, and shall provide the insurer's contact information for questions; and

(iii) provides notice of the issuance of the policy and rider to the superintendent in a form and manner acceptable to the superintendent.

§ 3. Section 4303 of the insurance law is amended by adding a new subsection (ss) to read as follows:

(ss)(1) Every policy which provides hospital, surgical, or medical coverage and which offers maternity care coverage pursuant to subsection (c) of this section shall also provide coverage for abortion services for an enrollee.

(2) Coverage for abortion shall not be subject to annual deductibles or coinsurance, including co-payments, unless the policy is a high deductible health plan as defined in section 223(c)(2) of the internal revenue code of 1986, in which case coverage for abortion may be subject to the plan's annual deductible.

(3) Notwithstanding any other provision, a group policy that provides hospital, surgical, or medical expense coverage delivered or issued for delivery in this state to a religious employer, as defined in paragraph five of subsection (cc) of this section, may exclude coverage for abortion only if the insurer:

(A) obtains an annual certification from the group policy holder that the policy holder is a religious employer and that the religious employer requests a contract without coverage for abortion;

(B) issues a rider to each certificate holder at no premium to be charged to the certificate holder or religious employer for the rider, that provides coverage for abortions subject to the same rules as would have been applied to the same category of treatment in the policy issued to the religious employer. The rider shall clearly and conspicuously specify that the religious employer does not administer abortion benefits, but that the insurer is issuing a rider for coverage of abortion, and shall provide the insurer's contact information for questions; and

(C) provides notice of the issuance of the policy and rider to the superintendent in a form and manner acceptable to the superintendent.

§ 4. Severability. If any provision of this act, or any application of any provision of this act, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this act, or of any other application of any provision of this act, which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 5. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date. Effective immediately, the addition, amendment, 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 S

Intentionally Omitted

PART T

Intentionally Omitted

PART U

Intentionally omitted

PART V

Section 1. Paragraphs (x) and (y) of subdivision 2 of section 2999-cc of the public health law, as amended by section 3 of part F of chapter 57 of the laws of 2021, are amended to read as follows:

(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) a mental health practitioner licensed pursuant to article one hundred sixty-three of the education law; and

(z) 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.

§ 2. Subdivision 1 of section 2999-dd of the public health law, as amended by chapter 124 of the laws of 2020, is amended to read as follows:

1. Health care services delivered by means of telehealth shall be entitled to reimbursement under section three hundred sixty-seven-u of the social services law on the same basis, at the same rate, and to the same extent the equivalent services, as may be defined in regulations promulgated by the commissioner, are reimbursed when delivered in person; provided, however, that health care services delivered by means of telehealth shall not require reimbursement to a telehealth provider for certain costs, including but not limited to facility fees or costs reimbursed through ambulatory patient groups or other clinic reimbursement methodologies set forth in section twenty-eight hundred seven of this chapter, if such costs were not incurred in the provision of telehealth services due to neither the originating site nor the distant site occurring within a facility or other clinic setting; and further provided, however, reimbursement for additional modalities, provider categories and originating sites specified in accordance with section twenty-nine hundred ninety-nine-ee of this article, and audio-only telephone communication defined in regulations promulgated pursuant to subdivision four of section twenty-nine hundred ninety-nine-cc of this article, shall be contingent upon federal financial participation. Notwithstanding the provisions of this subdivision, for services licensed, certified or otherwise authorized pursuant to article sixteen, article thirty-one or article thirty-two of the mental hygiene law, such services provided by telehealth, as deemed appropriate by the relevant commissioner, shall be reimbursed at the applicable in person rates or fees established by law, or otherwise established or certified by the office for people with developmental disabilities, office of mental health, or the office of addiction services and supports pursuant to article forty-three of the mental hygiene law.

§ 3. Subsection (a) of section 3217-h of the insurance law, as added by chapter 6 of the laws of 2015, is amended to read as follows:

(a) **(1)** An insurer shall not exclude from coverage a service that is otherwise covered under a policy that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that an insurer may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy. An insurer may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. An insurer may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(2) An insurer that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered by means of telehealth on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor distant site occur within the clinic or other facility.

(3) An insurer that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

§ 4. Subsection (a) of section 4306-g of the insurance law, as added by chapter 6 of the laws of 2015, is amended to read as follows:

(a) **(1)** A corporation shall not exclude from coverage a service that is otherwise covered under a contract that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth, as that term is defined in subsection (b) of this section; provided, however, that a corporation may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the contract. A corporation may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable to the insured as those established for the same service when not delivered via telehealth. A corporation may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

(2) A corporation that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered by means of telehealth on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility. The superintendent may promulgate regulations to implement the provisions of this section.

(3) A corporation that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

§ 5. Section 4406-g of the public health law is amended by adding two new subdivisions 3 and 4 to read as follows:

3. A health maintenance organization that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered via telehealth on the same basis, at the same rate, and to the extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered by means of telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor the distant site occur within the clinic or other facility. The commissioner, in consultation with the superintendent, may promulgate regulations to implement the provisions of this section.

4. A health maintenance organization that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

§ 6. The superintendent of financial services, in collaboration with the commissioner of health, shall report on the impact of reimbursement for telehealth services that, pursuant to the insurance law and public health law, will be reimbursed by an accident and health insurer and a corporation subject to article 43 of the insurance law, including a health maintenance organization, on the same basis, at the same rate, and to the same extent the equivalent services are reimbursed when delivered in person. The report shall, at a minimum, and to the extent possible, contain information regarding the use of telehealth services broken down by: social service district or county; age and gender of patients; procedure codes, diagnosis codes, and associated descriptions or modifiers; claims paid amount totals; claims information such as categories of services, specialty or type codes; and trends in the types of telehealth services used such as primary care, behavioral and mental health care, and the number of telehealth visits by provider type. The report shall include such utilization information dating from the effective date of this act and ending on the one-year anniversary of such effective date, and shall be submitted to the governor, the temporary president of the senate, and the speaker of the assembly by December 31, 2023.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, this act shall expire and be deemed repealed on and after April 1, 2024.

PART W

Section 1. Section 365-g of the social services law, as added by chapter 938 of the laws of 1990, subdivisions 1 and 3 as amended by chapter 165 of the laws of 1991, subdivisions 2 and 4 as amended by section 31 of part C of chapter 58 of the laws of 2008, clause (B) of subparagraph (iii) of paragraph (b) of subdivision 3 as amended by chapter 59 of the laws of 1993, subparagraphs (vi) and (vii) of paragraph (b) of subdivi-

sion 3 as amended and subparagraph (viii) as added by section 31-b of part C of chapter 58 of the laws of 2008, subdivision 5 as amended by chapter 41 of the laws of 1992, paragraphs (f) and (g) of subdivision 5 as amended by and paragraphs (h) and (i) as added by section 31-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

§ 365-g. Utilization [~~thresholds~~] review for certain care, services and supplies. 1. The department may implement a system for utilization [~~controls~~] review, pursuant to this section, for persons eligible for benefits under this title, [~~including annual service limitations or utilization thresholds above which the department may not pay for additional care, services or supplies, unless such care, services or supplies have been previously approved by the department or unless such care, services or supplies were provided pursuant to subdivision three, four or five of this section~~] to evaluate the appropriateness and quality of medical assistance, and safeguard against unnecessary utilization of care and services, which shall include a post-payment review process to develop and review beneficiary utilization profiles, provider service profiles, and exceptions criteria to correct misutilization practices of beneficiaries and providers; and for referral to the office of Medicaid inspector general where suspected fraud, waste or abuse are identified in the unnecessary or inappropriate use of care, services or supplies furnished under this title.

2. The department may [~~implement~~] review utilization [~~thresholds~~] by provider service type, medical procedure and patient, in consultation with the state department of mental hygiene, other appropriate state agencies, and other stakeholders including provider and consumer representatives. In [~~developing~~] reviewing utilization [~~thresholds~~], the department shall consider historical recipient utilization patterns, patient-specific diagnoses and burdens of illness, and the anticipated recipient needs in order to maintain good health. The system for utilization review shall not be used to determine a recipient's medical care, services or supplies under this section.

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

~~(a) prior notice to the recipients affected by the utilization threshold program, which notice must describe:~~

~~(i) the nature and extent of the utilization program, the procedures for obtaining an exemption from or increase in a utilization threshold, the recipients' fair hearing rights, and referral to an informational toll-free hot-line operated by the department; and~~

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

~~(b) procedures for:~~

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

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

~~(iii) requesting an exemption from utilization thresholds, which procedure must:~~

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

~~(B) provided for exemptions consistent with department guidelines for approving exemptions, which guidelines must be established by the~~

~~department in consultation with the department of health and, as appropriate, with the department of mental hygiene, and consistent with the current regulations of the office of mental health governing outpatient treatment.~~

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

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

~~(v) notifying recipients of and referring recipients to appropriate and accessible managed care programs and to preferred primary care providers designated pursuant to subdivision twelve of section twenty-eight hundred seven of the public health law at the same time such recipients are notified that they are nearing or have reached the utilization threshold for each specific provider type;~~

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

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

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

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

[~~5.~~] **4.** Utilization [~~thresholds~~] **review** established pursuant to this section shall not apply to services, even though such services might otherwise be subject to utilization [~~thresholds~~] **review**, when provided as follows:

(a) through a managed care program;

(b) subject to prior approval or prior authorization;

(c) as family planning services;

(d) as methadone maintenance services;

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

(f) for hemodialysis;

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

(h) pursuant to a court order; or

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

[~~6.~~] **5.** The department shall consult with representatives of medical assistance providers, social services districts, voluntary organizations that represent or advocate on behalf of recipients, the managed care advisory council and other state agencies regarding the ongoing operation of a utilization [~~threshold~~] **review** system.

[~~7.~~] **6.** On or before February first, nineteen hundred ninety-two, the commissioner shall submit to the governor, the temporary president of the senate and the speaker of the assembly a report detailing the implementation of the utilization threshold program and evaluating the results of establishing utilization thresholds. Such report shall include, but need not be limited to, a description of the program as implemented; the number of requests for increases in service above the threshold amounts by provider and type of service; the number of extensions granted; the number of claims that were submitted for emergency care or urgent care above the threshold level; the number of recipients referred to managed care; an estimate of the fiscal savings to the medical assistance program as a result of the program; recommendations for medical condition that may be more appropriately served through managed care programs; and the costs of implementing the program.

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

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

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

PART X

Intentionally Omitted

PART Y

Section 1. The domestic relations law is amended by adding a new section 20-c to read as follows:

§ 20-c. Certification of marriage; new certificate in case of subsequent change of name or gender. 1. A new marriage certificate shall be issued by the town or city clerk where the marriage license and certificate was issued, upon receipt of proper proof of a change of name or gender designation. Proper proof shall consist of: (a) a judgment, order or decree affirming a change of name or gender designation of either party to a marriage; (b) an amended birth certificate demonstrating a change of name or gender designation; (c) in the case of a change of gender designation, a notarized affidavit from the individual attesting to their change of gender designation; or (d) such other proof as may be established by the commissioner of health.

2. When a new marriage certificate is made pursuant to this section, the town or city clerk shall substitute such new certificate for the marriage certificate then on file, if any, and shall send the state

commissioner of health a digital copy of the new marriage certificate in a format prescribed by the commissioner, with the exception of the city clerk of New York who shall retain their copy. The town or city clerk shall make a copy of the new marriage certificate for the local record and hold the contents of the original marriage certificate confidential along with all supporting documentation, papers and copies pertaining thereto. It shall not be released or otherwise divulged except by order of a court of competent jurisdiction.

3. The town or city clerk shall be entitled to a fee of ten dollars for the amendment and certified copy of any marriage certificate in accordance with the provisions of this section.

4. The state commissioner of health may, in their discretion, report to the attorney general any town or city clerk that, without cause, fails to issue a new marriage certificate upon receipt of proper proof of a change of name or gender designation in accordance with this section. The attorney general shall thereupon, in the name of the state commissioner of health or the people of the state, institute such action or proceeding as may be necessary to compel the issuance of such new marriage certificate.

§ 2. This act shall take effect six months after it shall have become a law.

PART Z

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 K of chapter 57 of the laws of 2021, is amended to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012

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

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

§ 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 K of chapter 57 of the laws of 2021, is amended to read as follows:

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [~~and~~] between July 1, 2021 and June 30, 2022**, and between July 1, 2022 and June 30, 2023** 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

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§ 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 K of chapter 57 of the laws of 2021, are amended to read as follows:

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

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or

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

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

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018, and to the period July 1, 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020, and to the period July 1, 2020 to June 30, 2021, and to the period July 1, 2021 to June 30, 2022**, and to the period July 1, 2022 to June 30,**

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

§ 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 4 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

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

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

§ 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 5 of part K of chapter 57 of the laws of 2021, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, [~~and~~] June 15, 2022**, and June 15, 2023** the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July

1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022**, or July 1, 2022 to June 30, 2023** as applicable.

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

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

§ 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 6 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

§ 20. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent

excess coverage for the coverage period ending the thirtieth of June, two thousand [~~twenty-one~~] twenty-two, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [~~twenty-one~~] twenty-two; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand [~~twenty-one~~] twenty-two exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [~~twenty-one~~] twenty-two, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand [~~twenty-one~~] twenty-two, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [~~twenty-one~~] twenty-two and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [~~twenty-one~~] twenty-two.

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

PART AA

Section 1. This act enacts into law major components of legislation relating to the federal no surprises act and administrative simplification. Each component is wholly contained within a Subpart identified as Subparts A through C. The effective date for each particular provision contained within such Subpart is set forth in the last section of such Subpart. Any provision in any section contained within a Subpart, including the effective date of the Subpart, 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 Subpart in which it is found. Section three of this act sets forth the general effective date of this act.

SUBPART A

Section 1. Section 601 of the financial services law, as added by section 26 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

§ 601. Dispute resolution process established. The superintendent shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The superintendent shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The superintendent shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process of this article **for disputes that involve physician services**. To the extent practicable, the physician shall be licensed in

this state. **Disputes shall be submitted to an independent dispute resolution entity within three years of the date the health care plan made the original payment on the claim that is the subject of the dispute.**

§ 2. Subsection (b) of section 602 of the financial services law is REPEALED.

§ 3. Subsection (h) of section 603 of the financial services law, as added by section 26 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

(h) "Surprise bill" means a bill for health care services, other than emergency services, [~~received by~~] **with respect to**:

(1) an insured for services rendered by a non-participating [~~physician~~] **provider** at a participating hospital or ambulatory surgical center, where a participating [~~physician~~] **provider** is unavailable or a non-participating [~~physician~~] **provider** renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating [~~physician~~] **provider** is available and the insured has elected to obtain services from a non-participating [~~physician~~] **provider**;

(2) an insured for services rendered by a non-participating provider, where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan; or

(3) a patient who is not an insured for services rendered by a physician at a hospital or ambulatory surgical center, where the patient has not timely received all of the disclosures required pursuant to section twenty-four of the public health law.

§ 4. Section 604 of the financial services law, as amended by chapter 377 of the laws of 2019, is amended to read as follows:

§ 604. Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(a) whether there is a gross disparity between the fee charged by the [~~physician or hospital~~] **provider** for services rendered as compared to:

(1) fees paid to the involved [~~physician or hospital~~] **provider** for the same services rendered by the [~~physician or hospital~~] **provider** to other patients in health care plans in which the [~~physician or hospital~~] **provider** is not participating, and

(2) in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified [~~physicians or hospitals~~] **providers** for the same services in the same region who are not participating with the health care plan;

(b) the level of training, education and experience of the [~~physician~~] **health care professional**, and in the case of a hospital, the teaching staff, scope of services and case mix;

(c) the [~~physician's and hospital's~~] **provider's** usual charge for comparable services with regard to patients in health care plans in which the [~~physician or hospital~~] **provider** is not participating;

(d) the circumstances and complexity of the particular case, including time and place of the service;

(e) individual patient characteristics; [~~and, with regard to physician services,~~]

(f) the median of the rate recognized by the health care plan to reimburse similarly qualified providers for the same or similar services in the same region that are participating with the health care plan; and

(g) with regard to physician services, the usual and customary cost of the service.

§ 5. Subsections (a) and (c) of section 605 of the financial services law, as amended by chapter 377 of the laws of 2019, paragraphs 1 and 2 of subsection (a) as amended by section 1 of part YY of chapter 56 of the laws of 2020, are amended to read as follows:

(a) Emergency services for an insured. (1) When a health care plan receives a bill for emergency services from a non-participating [~~physician or hospital~~] **provider**, including a bill for inpatient services which follow an emergency room visit, the health care plan shall pay an amount that it determines is reasonable for the emergency services, including inpatient services which follow an emergency room visit, rendered by the non-participating [~~physician or hospital~~] **provider**, in accordance with section three thousand two hundred twenty-four-a of the insurance law, except for the insured's co-payment, coinsurance or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services, including inpatient services which follow an emergency room visit, than the insured would have incurred with a participating [~~physician or hospital~~] **provider**. [~~If an insured assigns benefits to a non-participating physician or hospital in relation to emergency services, including inpatient services which follow an emergency room visit, provided by such non-participating physician or hospital, the~~] **The** non-participating [~~physician or hospital~~] **provider** may bill the health care plan for the services rendered. Upon receipt of the bill, the health care plan shall pay the non-participating [~~physician or hospital~~] **provider** the amount prescribed by this section and any subsequent amount determined to be owed to the [~~physician or hospital~~] **provider** in relation to the emergency services provided, including inpatient services which follow an emergency room visit.

(2) A non-participating [~~physician or hospital~~] **provider** or a health care plan may submit a dispute regarding a fee or payment for emergency services, including inpatient services which follow an emergency room visit, for review to an independent dispute resolution entity.

(3) The independent dispute resolution entity shall make a determination within thirty **business** days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the non-participating [~~physician's or hospital's~~] **provider's** fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating [~~physician's or hospital's~~] **provider's** fee, that a settlement between the health care plan and non-participating [~~physician or hospital~~] **provider** is reasonably likely, or that both the health care plan's payment and the non-participating [~~physician's or hospital's~~] **provider's** fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating [~~physician or hospital~~] **provider** may be granted up to ten

business days for this negotiation, which shall run concurrently with the thirty **business** day period for dispute resolution.

(c) The determination of an independent dispute resolution entity shall be binding on the health care plan, [~~**physician or hospital**~~] **provider** and patient, and shall be admissible in any court proceeding between the health care plan, [~~**physician or hospital**~~] **provider** or patient, or in any administrative proceeding between this state and the [~~**physician or hospital**~~] **provider**.

§ 6. Subsection (d) of section 605 of the financial services law is REPEALED and subsection (e) of section 605 of the financial services law is relettered subsection (d).

§ 7. Section 606 of the financial services law, as amended by section 3 of part YY of chapter 56 of the laws of 2020, is amended to read as follows:

§ 606. Hold harmless [~~**and assignment of benefits**~~] for insureds **from bills for emergency services and surprise bills**. (a) [~~**When an insured assigns benefits for a surprise bill in writing to a non-participating physician that knows the insured is insured under a health care plan, the**~~] **A** non-participating [~~**physician**~~] **provider** shall not bill [~~**the**~~] **an** insured **for a surprise bill** except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating [~~**physician**~~] **provider**.

(b) [~~**When an insured assigns benefits for emergency services, including inpatient services which follow an emergency room visit, to a non-participating physician or hospital that knows the insured is insured under a health care plan, the**~~] **A** non-participating [~~**physician or hospital**~~] **provider** shall not bill [~~**the**~~] **an** insured **for emergency services, including inpatient services which follow an emergency room visit,** except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating [~~**physician or hospital**~~] **provider**.

§ 8. Subsections (a), (b) and (c) of section 607 of the financial services law, as added by section 26 of part H of chapter 60 of the laws of 2014, are amended to read as follows:

(a) Surprise bill [~~**received by**~~] **involving** an insured [~~**who assigns benefits**~~]. (1) [~~**If**~~] **For a surprise bill involving** an insured [~~**assigns benefits to a non-participating physician**~~], the health care plan shall pay the non-participating [~~**physician**~~] **provider** in accordance with paragraphs two and three of this subsection.

(2) The non-participating [~~**physician**~~] **provider** may bill the health care plan for the health care services rendered, and the health care plan shall pay the non-participating [~~**physician**~~] **provider** the billed amount or attempt to negotiate reimbursement with the non-participating [~~**physician**~~] **provider**.

(3) If the health care plan's attempts to negotiate reimbursement for health care services provided by a non-participating [~~**physician**~~] **provider** does not result in a resolution of the payment dispute between the non-participating [~~**physician**~~] **provider** and the health care plan, the health care plan shall pay the non-participating [~~**physician**~~] **provider** an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's copayment, coinsurance or deductible, in accordance with section three thousand two hundred twenty-four-a of the insurance law**, and shall ensure that the insured shall incur no greater out-of-pocket costs for the surprise bill than the insured would have incurred with a participating provider**.

(4) Either the health care plan or the non-participating [~~physician~~] provider may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity, provided however, the health care plan may not submit the dispute unless it has complied with the requirements of paragraphs one, two and three of this subsection.

(5) The independent dispute resolution entity shall make a determination within thirty business days of receipt of the dispute for review.

(6) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the non-participating [~~physician's~~] provider's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating [~~physician's~~] provider's fee, that a settlement between the health care plan and non-participating [~~physician~~] provider is reasonably likely, or that both the health care plan's payment and the non-participating [~~physician's~~] provider's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating [~~physician~~] provider may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty business day period for dispute resolution.

(b) Surprise bill received by [~~an insured who does not assign benefits or by~~] a patient who is not an insured.

(1) [~~An insured who does not assign benefits in accordance with subsection (a) of this section or a~~] A patient who is not an insured and who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity.

(2) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in section six hundred four of this article.

(3) A patient [~~or insured who does not assign benefits in accordance with subsection (a) of this section~~] shall not be required to pay the physician's fee to be eligible to submit the dispute for review to the independent dispute resolution entity.

(c) The determination of an independent dispute resolution entity shall be binding on the patient, [~~physician~~] provider and health care plan, and shall be admissible in any court proceeding between the patient or insured, [~~physician~~] provider or health care plan, or in any administrative proceeding between this state and the [~~physician~~] provider.

§ 9. Subsection (a) of section 608 of the financial services law, as amended by chapter 375 of the laws of 2019, is amended to read as follows:

(a) For disputes involving an insured, when the independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating [~~physician or hospital~~] provider. When the independent dispute resolution entity determines the non-participating [~~physician's or hospital's~~] provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan. When a good faith negotiation directed by the independent dispute resolution entity pursuant to paragraph four of subsection (a) of section six hundred five of this article, or paragraph

six of subsection (a) of section six hundred seven of this article results in a settlement between the health care plan and non-participating [~~physician or hospital~~] **provider**, the health care plan and the non-participating [~~physician or hospital~~] **provider** shall evenly divide and share the prorated cost for dispute resolution.

§ 10. Subparagraph (A) of paragraph 1 of subsection (b) of section 4910 of the insurance law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(A) the insured has had coverage of the health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service does not meet the health care plan's requirements for medical necessity, appropriateness, health care setting, level of care, [~~or~~] effectiveness of a covered benefit, **or other ground consistent with 42 U.S.C. § 300gg-19 as determined by the superintendent,** and

§ 11. Subparagraph (i) of paragraph (a) of subdivision 2 of section 4910 of the public health law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(i) the enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, pursuant to title one of this article on the grounds that such health care service does not meet the health care plan's requirements for medical necessity, appropriateness, health care setting, level of care, [~~or~~] effectiveness of a covered benefit, **or other ground consistent with 42 U.S.C. § 300gg-19 as determined by the commissioner in consultation with the superintendent of financial services,** and

§ 12. This act shall take effect immediately.

SUBPART B

Section 1. Paragraph 1 of subsection (c) of section 109 of the insurance law, as amended by section 55 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

(1) If the superintendent finds after notice and hearing that any authorized insurer, representative of the insurer, licensed insurance agent, licensed insurance broker, licensed adjuster, or any other person or entity licensed, certified, registered, or authorized pursuant to this chapter, has [~~wilfully~~] **willfully** violated the provisions of this chapter or any regulation promulgated thereunder **or with respect to accident and health insurance, any provision of titles one or two of division BB of the Consolidated Appropriations Act of 2021 (Pub. L. No. 116-260), as may be amended from time-to-time, and any regulations promulgated thereunder**, then the superintendent may order the person or entity to pay to the people of this state a penalty in a sum not exceeding one thousand dollars for each offense.

§ 2. Paragraph 17 of subsection (a) of section 3217-a of the insurance law, as amended by section 9 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, [~~and~~] telephone number**, and digital contact information** of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating

facilities certified or authorized by the office of mental health or the office of [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports, and any restrictions regarding the availability of the individual provider's services; and (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

§ 3. Section 3217-b of the insurance law is amended by adding two new subsections (m) and (n) to read as follows:

(m) A contract between an insurer and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the insurer's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

(n) A contract between an insurer and a health care provider shall include a provision that states that the provider shall reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the insured is provided with inaccurate network status information by the insurer in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the insurer provides inaccurate network status information to the insured indicating the provider was a participating provider when such provider was not a participating provider, the insurer shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. Nothing in this subsection shall prohibit a health care provider from requiring in the terms of a contract with an insurer that the insurer remove, at the time of termination of such contract, the provider from the insurer's provider directory or that the insurer bear financial responsibility for providing inaccurate network status information to an insured.

§ 4. Paragraph 17 of subsection (a) of section 4324 of the insurance law, as amended by section 34 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, [~~and~~] telephone number, and digital contact information of all participating providers, including facilities, and: (A) whether the provider is

accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports, and any restrictions regarding the availability of the individual provider's services; (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or termination of a provider from the corporation's network or a change in a physician's hospital affiliation;

§ 5. Section 4325 of the insurance law is amended by adding two new subsections (n) and (o) to read as follows:

(n) A contract between a corporation and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the corporation. A health care provider shall submit such provider directory information to a corporation, at a minimum, when a provider begins or terminates a network agreement with a corporation, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the corporation's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

(o) A contract between a corporation and a health care provider shall include a provision that states that the provider shall reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the insured is provided with inaccurate network status information by the corporation in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the corporation provides inaccurate network status information to the insured indicating the provider was a participating provider when such provider was not a participating provider, the corporation shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. Nothing in this subsection shall prohibit a health care provider from requiring in the terms of a contract with a corporation that the corporation remove, at the time of termination of such contract, the provider from the corporation's provider directory or that the corporation bear financial responsibility for providing inaccurate network status information to an insured.

§ 6. Section 4406-c of the public health law is amended by adding two new subdivisions 11 and 12 to read as follows:

11. A contract between a health care plan and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the health care plan. A health care provider shall submit such provider directory information to a health care plan, at a minimum, when a provider begins or terminates a network agreement with a health care plan, when there are material changes to the content of the provider directory information of such health care provider, and at any other time, including upon the health care plan's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

12. A contract between a health care plan and a health care provider shall include a provision that states that the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the commissioner in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the enrollee is provided with inaccurate network status information by the health care plan in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the health care plan provides inaccurate network status information to the enrollee indicating the provider was a participating provider when such provider was not a participating provider, the health care plan shall reimburse the provider for the out-of-network services regardless of whether the enrollee's coverage includes out-of-network services. Nothing in this subdivision shall prohibit a health care provider from requiring in the terms of a contract with a health care plan that the health care plan remove, at the time of termination of such contract, the provider from the health care plan's provider directory or that the health care plan bear financial responsibility for providing inaccurate network status information to an enrollee.

§ 7. Paragraph (r) of subdivision 1 of section 4408 of the public health law, as amended by section 41 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address [~~and~~], telephone number**, and digital contact information** of all participating providers, including facilities, and: (i) whether the provider is accepting new patients; (ii) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of [~~alcoholism~~] **addiction services** and [~~substance abuse services~~] **supports**, and any restrictions regarding the availability of the individual provider's services; and (iii) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the health maintenance organization's website and the health maintenance organization shall update the website

within fifteen days of the addition or termination of a provider from the health maintenance organization's network or a change in a physician's hospital affiliation;

§ 8. Subdivision 8 of section 24 of the public health law is renumbered subdivision 9 and a new subdivision 8 is added to read as follows:

8. A health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center defined under 42 U.S.C. § 254b on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center, and a hospital shall make publicly available, and if applicable, post on their public websites, and provide to individuals who are enrollees of health care plans, a one-page written notice, in clear and understandable language, containing information on the requirements and prohibitions under 42 U.S.C. §§ 300gg-131 and 300gg-132 and article six of the financial services law relating to prohibitions on balance billing for emergency services and surprise bills, and information on contacting appropriate state and federal agencies if an individual believes a health care provider has violated any requirement described in 42 U.S.C. §§ 300gg-131 and 300gg-132 or article six of the financial services law.

§ 9. Subsection (e) of section 4804 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(e) (1) If an insured's health care provider leaves the insurer's in-network benefits portion of its network of providers for a managed care product for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph one of subsection (b) of section forty-eight hundred three of this chapter, the insurer shall **provide written notice to the insured of the provider's disaffiliation and** permit the insured to continue an ongoing course of treatment with the insured's current health care provider during a transitional period of [~~(i) up to~~]**: (A)** ninety days from **the later of** the date of **the** notice to the insured of the provider's disaffiliation from the insurer's network **or the effective date of the provider's disaffiliation from the insurer's network**; or [~~(ii)~~] **(B)** if the insured [~~has entered the second trimester of pregnancy~~] **is pregnant** at the time of the provider's disaffiliation, [~~for a transitional period that includes~~] the [~~provision of~~] **duration of the pregnancy and** post-partum care directly related to the delivery.

(2) [~~Notwithstanding the provisions of paragraph one of this subsection, such care shall be authorized by the insurer during~~] **During** the transitional period [~~only if~~] the health care provider [~~agrees (i) to~~] **shall: (A)** continue to accept reimbursement from the insurer at the rates applicable prior to the start of the transitional period**, and continue to accept the in-network cost-sharing from the insured, if any,** as payment in full; [~~(ii) to~~] **(B)** adhere to the insurer's quality assurance requirements and [~~to~~] provide to the insurer necessary medical information related to such care; and [~~(iii) to~~] **(C)** otherwise adhere to the insurer's policies and procedures including, but not limited to**,** procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the insurer.

§ 10. Paragraph (e) of subdivision 6 of section 4403 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(e) (1) If an enrollee's health care provider leaves the health maintenance organization's network of providers for reasons other than those for which the provider would not be eligible to receive a hearing pursu-

ant to paragraph a of subdivision two of section forty-four hundred six-d of this chapter, the health maintenance organization shall **provide written notice to the enrollee of the provider's disaffiliation and** permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of**:** (i) [~~up to~~] ninety days from the **later of the** date of **the** notice to the enrollee of the provider's disaffiliation from the organization's network **or the effective date of the provider's disaffiliation from the organization's network**; or (ii) if the enrollee [~~has entered the second trimester of pregnancy~~] **is pregnant** at the time of the provider's disaffiliation, [~~for a transitional period that includes~~] the [~~provision of~~] **duration of the pregnancy and** post-partum care directly related to the delivery.

(2) [~~Notwithstanding the provisions of subparagraph one of this paragraph, such care shall be authorized by the health maintenance organization during~~] **During** the transitional period [~~only if~~] the health care provider [~~agrees~~] **shall:** (i) [~~to~~] continue to accept reimbursement from the health maintenance organization at the rates applicable prior to the start of the transitional period**, and continue to accept the in-network cost-sharing from the enrollee, if any,** as payment in full; (ii) [~~to~~] adhere to the organization's quality assurance requirements and to provide to the organization necessary medical information related to such care; and (iii) [~~to~~] otherwise adhere to the organization's policies and procedures, including but not limited to procedures regarding referrals and obtaining pre-authorization and a treatment plan approved by the organization.

§ 11. This act shall take effect immediately.

SUBPART C

Section 1. Section 3217-d of the insurance law is amended by adding a new subsection (e) to read as follows:

(e) An insurer that issues a comprehensive policy that uses a network of providers and is not a managed care health insurance contract, as defined in subsection (c) of section four thousand eight hundred one of this chapter, shall establish and maintain procedures for health care professional applications and terminations consistent with the requirements of section four thousand eight hundred three of this chapter and procedures for health care facility applications consistent with section four thousand eight hundred six of this chapter.

§ 2. Section 4306-c of the insurance law is amended by adding a new subsection (e) to read as follows:

(e) A corporation, including a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter and a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter as added by chapter 246 of the laws of 2012, that issues a comprehensive policy that uses a network of providers and is not a managed care health insurance contract, as defined in subsection (c) of section four thousand eight hundred one of this chapter, shall establish and maintain procedures for health care professional applications and terminations consistent with the requirements of section four thousand eight hundred three of this chapter and procedures for health care facility applications consistent with section four thousand eight hundred six of this chapter.

§ 3. The insurance law is amended by adding a new section 4806 to read as follows:

§ 4806. Health care facility applications. (a) An insurer that offers a managed care product shall, upon request, make available and disclose to facilities written application procedures and minimum qualification requirements that a facility must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified facilities in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the facility's application to participate in the in-network portion of the insurer's network and, within sixty days of receiving a facility's completed application to participate in the insurer's network, shall notify the facility as to: (1) whether the facility is credentialed; or (2) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

(b) For the purposes of this section, "facility" shall mean a health care provider that is licensed or certified pursuant to article five, twenty-eight, thirty-six, forty, forty-four, or forty-seven of the public health law or article sixteen, nineteen, thirty-one, thirty-two, or thirty-six of the mental hygiene law.

§ 4. The public health law is amended by adding a new section 4406-h to read as follows:

§ 4406-h. Health care facility applications. 1. A health care plan shall, upon request, make available and disclose to facilities written application procedures and minimum qualification requirements that a facility must meet in order to be considered by the health care plan for participation in the in-network benefits portion of the health care plan's network. The health care plan shall consult with appropriately qualified facilities in developing its qualification requirements. A health care plan shall complete review of the facility's application to participate in the in-network portion of the health care plan's network and shall, within sixty days of receiving a facility's completed application to participate in the health care plan's network, notify the facility as to: (a) whether the facility is credentialed; or (b) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, a health care plan shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

2. For the purposes of this section, "facility" shall mean a health care provider entity or organization that is licensed or certified pursuant to article five, twenty-eight, thirty-six, forty, forty-four, or forty-seven of this chapter or article sixteen, nineteen, thirty-one, thirty-two, or thirty-six of the mental hygiene law.

§ 5. Subsection (g) of section 4905 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(g) When making prospective, concurrent and retrospective determinations, utilization review agents shall collect only such information as is necessary to make such determination and shall not routinely require health care providers to numerically code diagnoses or proce-

dures to be considered for certification or routinely request copies of medical records of all patients reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to such review are medically necessary. In such cases, only the necessary or relevant sections of the medical record shall be required. A utilization review agent may request copies of partial or complete medical records retrospectively. [~~This subsection shall not apply to health maintenance organizations licensed pursuant to article forty-three of this chapter or certified pursuant to article forty-four of the public health law.~~]

§ 6. Subdivision 7 of section 4905 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

7. When making prospective, concurrent and retrospective determinations, utilization review agents shall collect only such information as is necessary to make such determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification or routinely request copies of medical records of all patients reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to such review are medically necessary. In such cases, only the necessary or relevant sections of the medical record shall be required. A utilization review agent may request copies of partial or complete medical records retrospectively. [~~This subdivision shall not apply to health maintenance organizations licensed pursuant to article forty-three of the insurance law or certified pursuant to article forty-four of this chapter.~~]

§ 7. This act shall take effect immediately; provided, however, that sections one through four of this act shall apply to credentialing applications received on or after the ninetieth day after this act shall have become a law; and provided further, that sections five and six of this act shall apply to health care services performed on or after the ninetieth day after this act shall have become a law.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or subpart 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 subpart 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 dates of Subparts A through C of this act shall be as specifically set forth in the last section of such Subparts.

PART BB

Intentionally Omitted

PART CC

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

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

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

(ii) Existing assisted living program providers may apply for approval to add up to nine additional assisted living program beds that do not require major renovation or construction under an expedited review process. The expedited review process is available to applicants that are in good standing with the department of health, and are in compliance with appropriate state and local requirements as determined by the department of health. The expedited review process shall allow certification of the additional beds for which the commissioner of health is satisfied that public need exists within ninety days of such department's receipt of a satisfactory application.

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

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

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

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

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

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, and for the state fiscal year beginning April 1, 2016 through March 31, 2019, and for the state fiscal year beginning April 1, 2019 through March 31, 2022, and for the state fiscal year beginning April 1, 2022 through March 31, 2025, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801

of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

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

§ 5. This act shall take effect on the one hundred twentieth day after it shall have become a law, provided, however, that the provisions of sections two, three, and four of this act shall expire and be deemed repealed July 1, [~~2022~~] 2024; provided, however, that the amendments to subdivision 1 of section 6801 of the education law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 8 of chapter 563 of the laws of 2008,

when upon such date the provisions of section one-a of this act shall take effect; provided, further, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

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

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

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

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

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

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

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

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

§ 3. This act shall take effect on the same date and in the same manner as a chapter of the laws of 2019, amending the public health law

relating to establishing the rare disease advisory council, as proposed in legislative bills numbers S. 4497 and A. 5762; provided, however, that the provisions of section two of this act shall expire and be deemed repealed [~~three~~] four years after such effective date.

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

§ 5. A report of the findings and recommendations of the task force and any proposed legislation necessary to implement such findings shall be filed with the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate, and the minority leader of the assembly on or before November first, two thousand [~~twenty-one~~] twenty-two.

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

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

PART DD

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners of the office of mental health, office for people with developmental disabilities, office of addiction services and supports, office of temporary and disability assistance, office of children and family services, and the state office for the aging shall establish a state fiscal year 2022-23 cost of living adjustment (COLA), effective April 1, 2022, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in paragraphs (i), (ii), (iii), (iv), (v), and (vi) of subdivision four of this section. The COLA established herein shall be applied to the appropriate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the department of health (DOH) shall be made as reimbursement for the state share of medical assistance.

2. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefore, for the period of April 1, 2022 through March 31, 2023, the commissioners shall provide funding to support a five and four-tenths percent (5.4%) cost of living adjustment under this section for all eligible programs and services as determined pursuant to subdivision four of this section.

3. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 5.4 percent cost of living adjustment (COLA) established herein shall be inclusive of all other cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2022. Except for the 5.4 percent cost of living adjustment (COLA) established herein, for the period commencing on April 1, 2022 and ending March 31, 2023 the commissioners shall not

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

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

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

services; family education and training; fiscal intermediary; support broker; and personal resource accounts.

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

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

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

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

5. Each local government unit or direct contract provider receiving funding for the cost of living adjustment established herein shall submit a written certification, in such form and at such time as each commissioner shall prescribe, attesting how such funding will be or was used to first promote the recruitment and retention of non-executive direct care staff, non-executive direct support professionals, non-exe-

cutive clinical staff, or respond to other critical non-personal service costs prior to supporting any salary increases or other compensation for executive level job titles.

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

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

PART EE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) "Certified peer specialist" means an individual who is certified as a peer in New York state from a certifying authority recognized by the commissioner of the office of mental health.

(8) "Certified recovery peer advocate" means an individual who holds a certification issued by an entity approved and recognized by the commissioner of the office of addiction services and supports.

(9) "Credentialed family peer advocate" means an individual who is credentialed as a peer in New York state from a certifying authority recognized by the commissioner of the office of mental health or the commissioner of the office of addiction services and supports.

(10) "Credentialed youth peer advocate" means an individual who is credentialed as a peer in New York state from a certifying authority recognized by the commissioner of the office of mental health or the commissioner of the office of addiction services and supports.

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

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

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

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

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

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

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

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

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

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

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

(8) A designated hotline center shall provide follow-up services as needed to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline consistent with guidance and policies established by New York State and the NSPL.

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

(d) The commissioner of the office of mental health, in conjunction with the commissioner of the office of addiction services and supports, shall establish a comprehensive list of reporting metrics regarding the 9-8-8 suicide prevention and behavioral health crisis hotline's usage, services and impact which, to the maximum extent practicable, shall include, at a minimum:

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

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

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

(4) The number of mobile crisis teams dispatched;

(5) The number of individuals engaged by mobile crisis teams;

(6) The number of individuals transported by mobile crisis teams to crisis intervention services or other behavioral health crisis services;

(7) The number of individuals engaged by mobile crisis teams transported to an emergency room;

(8) The number of individuals transferred by mobile crisis teams to the custody of law enforcement;

(9) The number of times a mobile crisis team was the first responder to a behavioral health crisis and the mobile crisis team had to request deployment of law enforcement; and

(10) The age, gender, race, and ethnicity of the individual, if reasonably ascertainable, of individuals contacted, transported, or transferred by each mobile crisis team.

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

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

§ 3. This act shall take effect immediately.

PART FF

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

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

the purpose of increasing investment in community based behavioral health services, including residential services certified by the office of [~~alcoholism and substance abuse~~] addiction services and supports. The methodologies used to calculate the savings shall be developed by the commissioner of health and the director of the budget in consultation with the commissioners of the office of mental health and the office of [~~alcoholism and substance abuse~~] addiction services and supports. In no event shall the full annual value of the [~~community based behavioral health service~~] reinvestment [~~savings attributable to the transition to managed care~~] pursuant to this subdivision exceed the [~~twelve month value of the department of health general fund reductions resulting from such transition~~] value of the premiums recovered from managed care providers which represent a reduction of spending on qualifying behavioral health services. Within any fiscal year where appropriation increases are recommended for reinvestment, insofar as managed care transition savings do not occur as estimated, [~~and general fund savings do not result,~~] then spending for such reinvestment may be reduced in the next year's annual budget itemization. [~~The commissioner of health shall promulgate regulations, and prior to October first, two thousand fifteen, may promulgate emergency regulations as required to distribute funds pursuant to this subdivision; provided, however, that any emergency regulations promulgated pursuant to this section shall expire no later than December thirty-first, two thousand fifteen.~~]

(b) Beginning April first, two thousand twenty-two, the department shall post on its website information about the recovery of premiums from managed care providers which represent a reduction of spending on qualifying behavioral health services against established premium targets for behavioral health services and the medical loss ratio applicable to special needs managed care plans. Such information shall include at a minimum: (i) a copy of the department's notification to each managed care provider that seeks a recovery of such premiums; and (ii) a list of managed care providers by name that have been subject to a recovery of such premiums, specifying the amount of premium that has been recovered from each managed care provider and year. In the initial posting, the department shall include all premiums recovered to date as required by this subdivision, by named managed care provider, amount and year.

(c) The commissioner shall include [~~detailed descriptions of the methodology used to calculate savings~~] information regarding the funds available for reinvestment[~~, the results of applying such methodologies, the details regarding implementation of such reinvestment~~], including how savings are calculated and how the reinvestment was utilized pursuant to this section[~~, and any regulations promulgated under this subdivision,~~] in the annual report required under section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen.

§ 2. This act shall take effect immediately.

PART GG

Section 1. 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 7 of part S of chapter 57 of the laws of 2021, 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, [~~2022~~] 2024.

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

PART HH

Intentionally Omitted

PART II

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

38. "Residential services facility" or "Alcoholism community residence" means any facility licensed or operated pursuant to article thirty-two of this chapter which provides residential services for the treatment of an addiction disorder and a homelike environment, including room, board and responsible supervision as part of an overall service delivery system. Provided however, "certified recovery residence" as defined in subdivision fifty-nine of this section shall not be considered a residential services facility for the purposes of this chapter.

59. "Certified recovery residence" means a shared living environment in the state that has been certified by the office of addiction services and supports and utilizes connection to services to promote sustained recovery from a substance use disorder.

§ 2. Subdivision (a) of section 32.05 of the mental hygiene law is amended by adding a new paragraph 1-a to read as follows:

1-a. operation of a certified recovery residence in accordance with section 32.05-a of this article for the promotion of sustained recovery of persons suffering from a substance use disorder;

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

§ 32.05-a Certified recovery residences.

1. The commissioner shall promulgate regulations consistent with this section for the voluntary certification of certified recovery residences.

2. Such regulations shall be evidence-based, utilizing information from sources with expertise in treatment and recovery. Such regulations shall, at a minimum, provide guidance for:

(a) staffing;

(b) referrals to and coordination with community and peer based supports including support related to co-occurring disorders;

(c) resident safety;

(d) resident rights;

(e) confidentiality;

(f) reoccurance support;

(g) application of tenants rights;

(h) administrative and operational policies and procedures; and

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

3. Once the commissioner has certified a location as a certified recovery residence, such certified recovery residence shall be included

on the office's website as an available option for individuals seeking such an environment.

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

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

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

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

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

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

PART JJ

Intentionally Omitted

PART KK

Intentionally Omitted

PART LL

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

§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health are authorized,

subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article **36,** 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of the office of mental health, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports**, or the office of mental health for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~1~~] **18** of part [~~P~~] **E** of chapter 57 of the laws of [~~2017~~] **2019** through March 31, [~~2023~~] **2027** for patients in the city of New York, for all rate periods on and after the effective date of section [~~1~~] **18** of part [~~P~~] **E** of chapter 57 of the laws of [~~2017~~] **2019** through March 31, [~~2023~~] **2027** for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through March 31, [~~2023~~] **2027** for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies.

Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

2. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 36, 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology or any such other fees established pursuant to the Medicaid state plan. The commissioner of health shall consult with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through March 31, [~~2023~~] 2027, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

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

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and [~~alcoholism and substance abuse~~] addiction services and supports are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed

pursuant to article 28 of the public health law, or pursuant to article **36,** 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports**, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of [~~alcoholism and substance abuse~~] **addiction** services **and supports** for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and [~~alcoholism and substance abuse~~] **addiction** services **and supports**, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~2~~] **19** of part [~~P~~] **E** of chapter 57 of the laws of [~~2017~~] **2019** through March 31, [~~2023~~] **2027** for patients in the city of New York, for all rate periods on and after the effective date of section [~~2~~] **19** of part [~~P~~] **E** of chapter 57 of the laws of [~~2017~~] **2019** through March 31, [~~2023~~] **2027** for patients outside the city of New York, and for all rate periods on and after the effective date of section [~~2~~] **19** of part [~~P~~] **E** of chapter 57 of the laws of [~~2017~~] **2019** through March 31, [~~2023~~] **2027** for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the office of mental health in determining whether such alternative rates shall be approved. The

commissioner of health may, in consultation with the commissioners of mental health and [~~alcoholism and substance abuse~~] addiction services and supports, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

b. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 36, 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law, shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology. The commissioner of health shall consult with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through March 31, [~~2023~~] 2027, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title 1-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

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

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

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

PART MM

Intentionally Omitted

PART NN

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

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

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

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

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

PART OO

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

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

§ 2. This act shall take effect immediately.

PART PP

Section 1. Subdivision 4 of section 365-f of the social services law is REPEALED.

§ 2. The opening paragraph of subparagraph (i) of paragraph (a) of subdivision 4-a of section 365-f of the social services law, as amended by section 3 of part G of chapter 57 of the laws of 2019, is amended to read as follows:

"Fiscal intermediary" means an entity that provides fiscal intermediary services and has a contract for providing such services with the department of health and is selected through the procurement process described in [~~paragraph~~] **paragraphs** (b)**, (b-1), (b-2) and (b-3)** of this subdivision. Eligible applicants for contracts shall be entities that

are capable of appropriately providing fiscal intermediary services, performing the responsibilities of a fiscal intermediary, and complying with this section, including but not limited to entities that:

§ 3. Paragraph (b-1) of subdivision 4-a of section 365-f of the social services law, as added by section 2 of part LL of chapter 57 of the laws of 2021, is amended to read as follows:

(b-1) Following the initial selection of contractors **on February eleventh, two thousand twenty-one,** pursuant to **the commissioner's request for offers #20039 ("RFO") in accordance with** 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~~] **accept the offer to enter into contracts with** all applicants **that were not initially selected on February eleventh, two thousand twenty-one, but** 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~~] **RFO, provided that such qualified applicants that were not initially selected attest that**:

(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~~] **the applicant was providing fiscal intermediary services for at least two hundred consumers in a city with a population of more than one million at any time between January first, two thousand twenty and March thirty-first, two thousand twenty; or**

(ii) the applicant was providing fiscal intermediary services for at least fifty consumers in another area of the state at any time between January first, two thousand twenty and March thirty-first, two thousand twenty.

§ 4. Paragraphs (b-2) and (b-3) of subdivision 4-a of section 365-f of the social services law are REPEALED and two new paragraphs (b-2) and (b-3) are added to read as follows:

(b-2) Upon the publication of an attestation form or process to the department's website, the remaining qualified applicants described in paragraph (b-1) of this subdivision shall have sixty days to submit an

attestation and all required supporting documentation to the commissioner.

(i) Any late submission shall disqualify the applicant from receiving a contract award under paragraph (b-1) of this subdivision.

(ii) The number of consumers served by an applicant during the period between January first, two thousand twenty and March thirty-first, two thousand twenty may be measured by the greatest number of consumers served in the specified region by the applicant on any day during that period.

(iii) Applicant attestations shall be audited by the office of Medicaid inspector general, and any false or inaccurate attestation shall render any contract awarded under paragraph (b-1) of this subdivision null and void; this provision shall not be construed to limit or supersede any other applicable sanctions or penalties that may be imposed under the medical assistance program.

(b-3) Contracts awarded under paragraph (b-1) of this subdivision shall be limited to the service areas indicated on the applicants' submission to the RFO.

§ 5. This act shall take effect immediately.

PART QQ

Section 1. Subdivision 10 of section 365-a of the social services law, as added by section 11 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

10. The department of health shall establish or procure the services of an independent assessor or assessors no later than October 1, 2022, in a manner and schedule as determined by the commissioner of health, to take over from local departments of social services, Medicaid Managed Care providers, and Medicaid managed long term care plans performance of assessments and reassessments required for determining individuals' needs for personal care services, including as provided through the consumer directed personal assistance program, and other services or programs available pursuant to the state's medical assistance program as determined by such commissioner for the purpose of improving efficiency, quality, and reliability in assessment and to determine individuals' eligibility for Medicaid managed long term care plans. Notwithstanding the provisions of section one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any contrary provision of law, contracts may be entered or the commissioner may amend and extend the terms of [~~a contract awarded prior to the effective date and entered into pursuant to subdivision twenty-four of section two hundred six of the public health law, as added by section thirty-nine of part C of chapter fifty-eight of the laws of two thousand eight, and~~] a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, if such contract or contract amendment is for the purpose of procuring such assessment services from an independent assessor[~~; provided, however, in the case of a contract entered into after the effective date of this section, that:~~

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

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

~~(ii) The criteria for selection of a contractor or contractors including, but not limited to, being unaffiliated with any entity certified under article forty-four of the public health law or any service provider licensed under article thirty-six of the public health law, demonstrated cultural and linguistic competence, experience in evaluating the service needs of individuals with disabilities seeking to live in the community, and demonstrated compliance with all applicable state and federal laws. Furthermore, the selection criteria shall consider and give preference to whether a prospective contractor is a not-for-profit organization;~~

~~(iii) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and~~

~~(iv) The manner by which a prospective contractor may submit a proposal for selection, which may include submission by electronic means;~~

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

~~(c) The commissioner of health shall select such contractor or contractors that are best suited to serve the purposes of this section and the needs of recipients; and~~

~~(d) All decisions made and approaches taken pursuant to this section shall be documented in a procurement record as defined in section one hundred sixty-three of the state finance law~~]. **Contracts entered into, amended, or extended pursuant to this subdivision shall not remain in force beyond September 30, 2025**.

§ 2. Section 8 of part C of chapter 57 of the laws of 2018, amending the social services law and the public health law relating to health homes and penalties for managed care providers, as amended by section 12 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

§ 8. Notwithstanding any inconsistent provision of [~~section~~] **sections 112 and** 163 of the state finance law, or sections 142 and 143 of the economic development law, or any other contrary provision of law, excepting the 13 responsible vendor requirements of the state finance law, including, but not limited to, sections 163 and 139-k of the state finance law, the commissioner of health is authorized to amend or otherwise extend the terms of a contract awarded prior to the effective date and entered into pursuant to subdivision 24 of section 206 of the public health law, as added by section 39 of part C of chapter 58 of the laws of 2008[~~, and a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, both for a period of three years~~], without a competitive bid or request for proposal process, upon determination that the existing contractor is qualified to continue to provide such services, and provided that efficiency savings are achieved during the period of extension; and provided, further, that the department of health shall submit a request for applications for such contract during the time period specified in this section and may terminate the contract identified herein prior to expiration of the extension authorized by this section. **Contracts entered into, amended, or extended pursuant to this section shall not remain in force beyond August 19, 2026.**

§ 3. Section 20 of part MM of chapter 56 of the laws of 2020, directing the department of health to establish or procure the services of an

independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, is amended to read as follows:

§ 20. The department of health shall establish or procure services of an independent panel or panels of clinical professionals no later than October 1, 2022, in a manner and schedule as determined by the commissioner of health, to provide as appropriate independent physician or other applicable clinician orders for personal care services, including as provided through the consumer directed personal assistance program, available pursuant to the state's medical assistance program and to determine eligibility for the consumer directed personal assistance program. Notwithstanding the provisions of section 163 of the state finance law, or sections 142 and 143 of the economic development law, or any contrary provision of law, contracts may be entered or the commissioner **of health** may amend and extend the terms of [~~a contract awarded prior to the effective date and entered into pursuant to subdivision twenty-four of section two hundred six of the public health law, as added by section thirty-nine of part C of chapter fifty-eight of the laws of two thousand eight, and~~] a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, if such contract or contract amendment is for the purpose of establishing an independent panel or panels of clinical professionals as described in this section[~~; provided, however, in the case of a contract entered into after the effective date of this section, that:~~

~~(a) The department of health shall post on its website, for a period of no less than 30 days:~~

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

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

~~(iii) The period of time during which a prospective contractor may seek to be selected by the department of health, which shall be no less than 30 days after such information is first posted on the website; and~~

~~(iv) The manner by which a prospective contractor may submit a proposal for selection, which may include submission by electronic means;~~

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

~~(c) The commissioner of health shall select such contractor or contractors that, in such commissioner's discretion, are best suited to serve the purposes of this section and the needs of recipients; and~~

~~(d) all decisions made and approaches taken pursuant to this section shall be documented in a procurement record as defined in section one hundred sixty-three of the state finance law~~]**. Contracts entered into, amended, or extended pursuant to this section shall not remain in force beyond September 30, 2025**.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022 and shall apply to all contracts entered into, amended, or extended on or after it shall have taken effect.

PART RR

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

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

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

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

§ 5. This act shall take effect immediately and shall be deemed repealed [~~two~~] **five** years after such effective date.

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

PART SS

Section 1. 1. The department of health shall conduct a study within Kings county to determine ways to improve access to health services and facilities.

(a) In reviewing accessibility to services and facilities in Kings county, the study shall consider inequities in the health care system in such county, including, but not limited to, racial, ethnic, sex, immigration status, and socio-economic status disparities that may impose barriers to care.

(b) The study shall also consider the need for medical services for women and children in Kings county, including the need for construction of medical facilities serving women and children, or capital improvements to existing regional perinatal centers.

2. The department of health shall complete a report based on such study, which shall provide recommendations for the improvement of accessibility to health services and facilities in Kings county.

3. The study shall be completed within eighteen months of the effective date of this act and a report of the findings from the study shall

be presented to the governor, the speaker of the assembly and the temporary president of the senate within ninety days of the completion of the study.

§ 2. This act shall take effect immediately.

PART TT

Section 1. Section 26 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws, relating to targeted Medicaid reimbursement rate reductions, is amended to read as follows:

§ 26. Notwithstanding any provision of law to the contrary and subject to the availability of federal financial participation, for periods on and after April 1, 2011, clinics certified pursuant to [~~articles 16,~~] **article** 31 or 32 of the mental hygiene law shall be subject to targeted Medicaid reimbursement rate reductions in accordance with the provisions of this section. Such reductions shall be based on utilization thresholds which may be established either as provider-specific or patient-specific thresholds. Provider-specific thresholds shall be based on average patient utilization for a given provider in comparison to a peer based standard to be determined for each service. The commissioners of the office of mental health[~~, the office for persons with developmental disabilities,~~] and the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports**, in consultation with the commissioner of health, are authorized to waive utilization thresholds for patients of clinics certified pursuant to article [~~16,~~] 31[~~,~~] or 32 of the mental hygiene law who are enrolled in specific treatment programs or otherwise meet criteria as may be specified by such commissioners. When applying a provider-specific threshold, rates will be reduced on a prospective basis based on the amount any provider is over the determined threshold level. Patient-specific thresholds will be based on annual thresholds determined for each service over which the per visit payment for each visit in excess of the standard during a twelve month period shall be reduced by a pre-determined amount. The thresholds, peer based standards and the payment reductions shall be determined by the department of health, with the approval of the division of the budget, and in consultation with the office of mental health[~~, the office for people with developmental disabilities~~] and the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports**, and any such resulting rates shall be subject to certification by the appropriate commissioners pursuant to subdivision (a) of section 43.02 of the mental hygiene law. The base period used to establish the thresholds shall be the 2009 calendar year. The total annualized reduction in payments shall be not more than $10,900,000 for Article 31 clinics[~~, not more than $2,400,000 for Article 16 clinics,~~] and not more than $13,250,000 for Article 32 clinics. The commissioner of health may promulgate regulations to implement the provisions of this section.

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