STATE OF NEW YORK

4007--B

IN SENATE

February 1, 2023

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

AN ACT to repeal sections 91 and 92 of part H of chapter 59 of the laws of 2011 relating to the year to year rate of growth of Department of Health state funds and Medicaid funding, relating to the state Medicaid spending cap and related processes (Part A); to amend chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law relating to providing enhanced consumer and provider protections, in relation to the effectiveness of certain provisions relating to contracts between plans, insurers, or corporations and hospitals; to amend part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to adjustments of rates, in relation to the effectiveness of certain provisions relating to the amount of income to be applied toward the cost of medical care, services and supplies of institutionalized spouses; to amend chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, in relation to the effectiveness thereof; to amend the social services law, in relation to the age of eligibility for home and community-based services waivers; to amend chapter 313 of the laws of 2018, amending the public health law relating to body imaging scanning equipment, in relation to the effectiveness thereof; to amend chapter 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings, in relation to the effectiveness of certain provisions thereof; to amend chapter 582 of the laws of 1984, amending the public health law relating to regulating activities of physicians, in relation to the effectiveness of certain provisions thereof; to amend the public health law, in relation to extending the demonstration period in certain physician committees; to amend chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, in relation to the effectiveness thereof; to amend the public health law, in relation to

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

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reimbursement rate promulgation for residential health care facilities; to amend the public health law, in relation to certified home health agency services payments; to amend chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, in relation to the effectiveness thereof; to amend the public health law, in relation to continuing nursing home upper payment limit payments; to amend chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, in relation to the effectiveness thereof; to amend part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, in relation to the effectiveness of certain provisions relating to increasing information available to patients; to amend part H of chapter 59 of the laws of 2011, amending the public health law relating to the statewide health information network of New York and the statewide planning and research cooperative system and general powers and duties, in relation to making certain provisions permanent; to amend part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, in relation to extending the expiration of certain provisions 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 extending the effectiveness of certain provisions thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to extending the effectiveness of certain provisions thereof; to amend the social services law, in relation to the effectiveness of certain provisions relating to negotiation of supplemental rebates relating to medication assisted treatment; to amend part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to the effectiveness thereof; to amend part KK of chapter 56 of the laws of 2020, amending the public health law relating to the designation of statewide general hospital quality and sole community pools and the reduction of capital related inpatient expenses, in relation to the effectiveness thereof; to amend part C of chapter 60 of the laws of 2014, amending the social services law relating to fair hearings within the Fully Integrated Duals Advantage program, in relation to the effectiveness thereof; to amend chapter 779 of the laws of 1986, amending the social services law relating to authorizing services for non-residents in adult homes, residences for adults and enriched housing programs, in relation to extending the effectiveness of certain provisions thereof; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and adding an alternative payment meth-

odology requirement; and to amend the public health law, in relation to residential health care facility assessments; to amend part MM of chapter 57 of the laws of 2021 amending the public health law relating to aiding in the transition to adulthood for children with medical fragility living in pediatric nursing homes and other settings, in relation to the effectiveness thereof; to amend the social services law, in relation to coverage for services provided by school-based health centers for medical assistance recipients; and to amend part JJ of chapter 57 of the laws of 2021 amending the social services law relating to managed care programs, in relation to the effectiveness thereof (Part B); to amend part A3 of chapter 62 of the laws of 2003 amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, in relation to extending the effectiveness of provisions thereof; to amend the New York Health Care Reform Act of 1996, in relation to extending certain provisions relating thereto; to amend the New York Health Care Reform Act of 2000, in relation to extending the effectiveness of provisions thereof; to amend the public health law, in relation to extending certain provisions relating to the distribution of pool allocations and graduate medical education; to amend the public health law, in relation to extending certain provisions relating to health care initiative pool distributions; to amend the social services law, in relation to extending payment provisions for general hospitals; and to amend the public health law, in relation to extending certain provisions relating to the assessments on covered lives (Part C); intentionally omitted (Part D); to amend the public health law, in relation to amending and extending the voluntary indigent care pool; in relation to establishing the definition of rural emergency hospital; and in relation to expanding eligibility for vital access provider assurance program funding; and to amend part I of chapter 57 of the laws of 2022 relating to providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to Medicaid payments made for the operating component of hospital inpatient and outpatient services (Part E); 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, 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 F); to amend the elder law, in relation to programs for the aging (Part G); to amend the social services law, in relation to enacting the 1332 state innovation program; and to amend the state finance law, in relation to establishing the 1332 state innovation program fund (Part H); to amend the public health law, in relation to extending authority to enroll certain recipients in need of more than 120 days of community based-long term care in a managed long term care plan; to amend the public health law, in relation to extending the moratorium on the processing and approval of applications seeking a certificate of authority as a managed long term care plan, setting performance standards for managed

long term care plans; to amend part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to providing an additional increase to all qualifying fee-for-service Medicaid rates for the operating component of residential health care facilities services and an additional increase to all qualifying fee-for-service Medicaid rates for the operating component of assisted living programs; and to amend part H of chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund medical expenditures, in relation to extending the provisions thereof (Part I); intentionally omitted (Part J); to amend the social services law, in relation to authorizing Medicaid eligibility for certain services provided to individuals who are in a correctional institution, and for certain services provided to individuals who are in an institution for mental disease and provides for a workgroup to study qualified residential treatment programs; and providing for the repeal of certain provisions upon expiration thereof (Part K); to amend the insurance law, in relation to site of service review and coverage for services provided at hospital-based outpatient clinics (Part L); to amend the public health law, in relation to fees for construction of hospitals and to licensure requirements and reimbursements for certain home health services (Part M); to amend the social services law, in relation to expanding the Medicaid Buy-In program for people with disabilities (Part N); to amend the public health law, in relation to regulating the sale or distribution of flavored tobacco products (Part O); to amend the public health law, in relation to establishing a new statewide health care transformative program (Part P); to amend the social services law, in relation to establishing Medicaid reimbursement for community health workers (CHWs) for high-risk populations; and to amend the public health law, in relation to permitting licensed mental health counselors and licensed marriage and family therapists in community health centers to be reimbursed (Part Q); to amend the social services law and the public health law, in relation to expanding Medicaid coverage of preventative health care services (Part R); to amend the public health law, the education law, the civil service law, the retirement and social security law and the state finance law, in relation to modernizing the state of New York's emergency medical system and workforce; and to repeal section 3032 of the public health law relating thereto (Part S); to amend the multiple residence law, in relation to lead testing in certain multiple dwellings; and to amend the executive law, in relation to expanding the powers of the secretary of state with respect to the New York state uniform fire prevention and building code (Part T); to amend the general business law, in relation to providing for the protection of electronic health information (Part U); intentionally omitted (Part V); intentionally omitted (Part W); to amend the public health law, in relation to providing for the registration of temporary health care services agencies (Part X); to amend the civil practice law and rules and the judiciary law, in relation to affidavits for medical debt actions (Subpart A); to amend the insurance law, in relation to prescription drug price and supply chain transparency; and to amend the state finance law, in relation to funds deposited in the pharmacy benefit manager regulatory fund (Subpart B); to amend the public health law, in relation to requiring hospitals participating in the general hospital indigent care pool to use certain forms for the collection of medical debt

(Subpart C); and to amend the insurance law, in relation to guaranty fund coverage for insurers writing health insurance (Subpart D) (Part Y); to amend the public health law, in relation to quality improvement and increased consumer transparency in assisted living residences (Part Z); to amend the public health law, in relation to hepatitis C screening and requiring third trimester syphilis testing; and to amend chapter 425 of the laws of 2013 amending the public health law relating to requiring hospitals to offer hepatitis C testing, in relation to making such provisions permanent (Part AA); intentionally omitted (Part BB); intentionally omitted (Part CC); in relation to establishing a cost of living adjustment for designated human services programs (Part DD); to amend part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, in relation to the effectiveness of certain provisions thereof (Part EE); to amend the education law, in relation to expanding the description of certain services which are not prohibited by statutes governing the practice of nursing (Part FF); intentionally omitted (Part GG); to amend the mental hygiene law, in relation to certified community behavioral health clinics (Part HH); to amend the insurance law and the financial services law, in relation to insurance coverage for behavioral health services (Subpart A); to amend the insurance law and the public health law, in relation to utilization review standards for mental health services (Subpart B); to amend the insurance law and the public health law, in relation to telehealth payment parity (Subpart C); to amend the insurance law, in relation to private rights of action (Subpart D); to amend the insurance law, in relation to substance use disorder treatment (Subpart E); and to amend the insurance law and the public health law, in relation to network adequacy for mental health and substance use disorder services (Subpart F) (Part II); to amend the mental hygiene law, in relation to the imposition of sanctions by the commissioner of mental health (Part JJ); to amend the social services law, in relation to removing certain restrictions on access to home care services; and to repeal certain provisions of such law relating thereto (Part KK); to establish a task force on missing women and girls who are black, indigenous and people of color; and providing for the repeal of such provisions upon expiration thereof (Part LL); to amend the mental hygiene law, in relation to authorizing certain facilities to provide treatment for the mental health and health care needs of individuals admitted for a substance use disorder (Part MM); to amend the mental hygiene law, in relation to establishing the independent developmental disability ombudsman program (Part NN); to amend the social services law, in relation to the determination of eligibility for medical assistance benefits (Part OO); to amend the public health law and the state finance law, in relation to establishing a reproductive health services training grant program (Part PP); to amend the public health law, in relation to establishing the women's health education program for correctional facilities and rights of pregnant incarcerated individuals; to amend the public health law, in relation to requiring certain testing to be offered; to amend the correction law, in relation to providing pregnant incarcerated individuals with access to prenatal vitamins and a specialized diet; and to require the department of health to collect data on women's health care in prisons and publish a report (Part QQ); to amend the public health law, in relation to the minimum wage for home care aides; and

in relation to state-directed payments to providers of medicaid services for the purposes of supporting wage increases (Part RR); to amend the social services law, in relation to including doulas as medical services providers for Medicaid recipients; directing the commissioner of health to submit an application for amendments and waivers to add doulas to state Medicaid coverage; and providing minimum reimbursement levels for their services (Part SS); directing the commissioner of health to conduct a study on the rates of reimbursement made through the New York state Medicaid durable medical equipment, orthotics, prosthetics and supplies program for rate adequacy and patient access; and providing for the repeal of such provisions upon expiration thereof (Part TT); to amend the public health law, in relation to retroactive enrollment in the Child Health Insurance Plan (Part UU); to amend the social services law and the public health law, in relation to pharmacy services provided by managed care providers and to repeal sections 1 and 1-a of part FFF of chapter 56 of the laws of 2020 relating to directing the department of health to remove the pharmacy benefit from the managed care benefit package and to provide the pharmacy benefit under the fee for service program, in relation thereto (Part VV); to amend the public health law, in relation to pediatric residential health care facilities participating in a demonstration program for residential health care for children with medical fragility in transition to young adults and young adults with medical fragility (Part WW); to amend the social services law, in relation to reimbursement of transportation costs for certain enrollees under Medicaid (Part XX); in relation to prohibiting the Department of Health from disenrolling a participant in the Medicaid Health Home program based on the duration of time such participant has been enrolled in the program (Part YY); directing the office of mental health to convene workgroups on Black, Latina, and LGBTQ+ children and youth suicide prevention; and providing for the repeal of such provisions upon the expiration thereof (Part ZZ); to amend the public health law and the insurance law, in relation to the definition of clinical peer reviewer (Part AAA); to amend the public health law, in relation to enacting the reproductive freedom and equity grant program (Part BBB); to amend the public health law, in relation to reimbursement of pediatric diagnostic and treatment centers (Part CCC); to amend the public health law, in relation to establishing the office of hospice and palliative care access and quality (Part DDD); directing the commissioner of mental health to establish a maternal mental health workgroup to study and issue recommendations related to maternal mental health and perinatal and postpartum mood and anxiety disorders; and providing for the repeal of such provision upon expiration thereof (Part EEE); to amend the public health law, in relation to providing funding for certified home health agencies and hospice programs to increase services in underserved or hard to serve areas of the state (Part FFF); to amend the social services law and the public health law, in relation to establishing a quality incentive program for managed care providers (Part GGG); and to direct the office of mental health to convene a task force on implementing non-police responses to mental health, alcohol use, and substance use crises; and providing for the repeal of such provisions upon the expiration thereof (Part HHH)

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 2023-2024 state fiscal year. Each component is wholly contained within a Part identified as Parts A through HHH. 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. Sections 91 and 92 of part H of chapter 59 of the laws of 2011 relating to the year to year rate of growth of Department of Health state funds and Medicaid funding are REPEALED.

§ 2. This act shall take effect immediately.

PART B

Section 1. Subdivision 1 of section 20 of chapter 451 of the laws of 2007 amending the public health law, the social services law and the insurance law relating to providing enhanced consumer and provider protections, as amended by chapter 181 of the laws of 2021, is amended to read as follows:

1. sections four, eleven and thirteen of this act shall take effect immediately and shall expire and be deemed repealed June 30, [~~2023~~] **2025**;

§ 2. Subdivision 6-a of section 93 of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to adjustments of rates, as amended by section 2 of part T of chapter 57 of the laws of 2018, is amended to read as follows:

6-a. section fifty-seven of this act shall expire and be deemed repealed [~~on March 31, 2023~~] **March 31, 2028**; provided that the amendments made by such section to subdivision 4 of section 366-c of the social services law shall apply with respect to determining initial and continuing eligibility for medical assistance, including the continued eligibility of recipients originally determined eligible prior to the effective date of this act, and provided further that such amendments shall not apply to any person or group of persons if it is subsequently determined by the Centers for Medicare and Medicaid services or by a court of competent jurisdiction that medical assistance with federal financial participation is available for the costs of services provided to such person or persons under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

§ 3. Section 3 of chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, as amended by section 4 of part T of chapter 57 of the laws of 2018, is amended to read as follows:

§ 3. This act shall take effect on the thirtieth day after it shall have become a law and shall be of no further force and effect after [~~March 31, 2023~~] March 31, 2028, at which time the provisions of this act shall be deemed to be repealed.

§ 4. Subparagraph (i) of paragraph b of subdivision 6 of section 366 of the social services law, as amended by chapter 389 of the laws of 2008, is amended to read as follows:

(i) be [~~eighteen~~] twenty-one years of age or under;

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

(i) be [~~eighteen~~] twenty-one years of age or under;

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

(i) be under [~~eighteen~~] twenty-one years of age;

§ 7. Section 2 of chapter 313 of the laws of 2018, amending the public health law relating to body imaging scanning equipment, is amended to read as follows:

§ 2. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided, however, that, effective immediately, the addition, amendment, and/or repeal of any rules and regulations necessary to implement the provisions of this act on its effective date are directed to be completed on or before such effective date; and provided further, that this act shall expire and be deemed repealed [~~five years after such effective date~~] January 30, 2029.

§ 8. Section 5 of chapter 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings, as amended by chapter 106 of the laws of 2018, is amended to read as follows:

§ 5. This act shall take effect June 1, 1983 and shall remain in full force and effect until July 1, [~~2023~~] 2033.

§ 9. Section 5 of chapter 582 of the laws of 1984, amending the public health law relating to regulating activities of physicians, as amended by chapter 106 of the laws of 2018, is amended to read as follows:

§ 5. This act shall take effect immediately, provided however that the provisions of this act shall remain in full force and effect until July 1, [~~2023~~] 2033 at which time the provisions of this act shall be deemed to be repealed.

§ 10. Subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law, as amended by chapter 106 of the laws of 2018, is amended to read as follows:

(ii) Participation and membership during a three year demonstration period in a physician committee of the Medical Society of the State of New York or the New York State Osteopathic Society whose purpose is to confront and refer to treatment physicians who are thought to be suffering from alcoholism, drug abuse, or mental illness. Such demonstration period shall commence on April first, nineteen hundred eighty and terminate on May thirty-first, nineteen hundred eighty-three. An additional demonstration period shall commence on June first, nineteen hundred eighty-three and terminate on March thirty-first, nineteen hundred eighty-six. An additional demonstration period shall commence on April first, nineteen hundred eighty-six and terminate on March thirty-first, nineteen hundred eighty-nine. An additional demonstration period shall commence April first, nineteen hundred eighty-nine and terminate March thirty-first, nineteen hundred ninety-two. An additional demonstration period shall commence April first, nineteen hundred ninety-two and

terminate March thirty-first, nineteen hundred ninety-five. An additional demonstration period shall commence on April first, nineteen hundred ninety-five and terminate on March thirty-first, nineteen hundred ninety-eight. An additional demonstration period shall commence on April first, nineteen hundred ninety-eight and terminate on March thirty-first, two thousand three. An additional demonstration period shall commence on April first, two thousand three and terminate on March thirty-first, two thousand thirteen. An additional demonstration period shall commence April first, two thousand thirteen and terminate on March thirty-first, two thousand eighteen. An additional demonstration period shall commence April first, two thousand eighteen and terminate on July first, two thousand [~~twenty-three~~] **thirty-three** provided, however, that the commissioner may prescribe requirements for the continuation of such demonstration program, including periodic reviews of such programs and submission of any reports and data necessary to permit such reviews. During these additional periods, the provisions of this subparagraph shall also apply to a physician committee of a county medical society.

§ 11. Section 4 of chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, as amended by section 1 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 4. This act shall take effect immediately; provided, however, that the provisions of paragraph (b) of subdivision 4 of section 409-c of the public health law, as added by section three of this act, shall take effect January 1, 1996 and shall expire and be deemed repealed [~~twenty-eight years from the effective date thereof~~] **March 31, 2028**.

§ 12. Paragraph (b) of subdivision 17 of section 2808 of the public health law, as amended by section 15 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal years beginning April first, two thousand ten and ending March thirty-first, two thousand [~~twenty-three~~] **twenty-seven**, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand [~~twenty-three~~] **twenty-seven**, based on consideration of rate appeals filed by residential health care facilities or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for each such state fiscal year provided, however, that for the period April first, two thousand eleven through March thirty-first, two thousand twelve such aggregate annual amount shall be fifty million dollars. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such other considerations as the commissioner deems appropriate and, further, the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; provided, however, that the commissioner's authority to negotiate such agreements resolving multiple pending rate appeals as hereinbefore described shall continue on and after April first, two thousand [~~twenty-three~~] **twenty-seven**. Rate

adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

§ 13. Paragraph (a) of subdivision 13 of section 3614 of the public health law, as amended by section 16 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 and subject to the availability of federal financial participation, effective April first, two thousand twelve through March thirty-first, two thousand [~~twenty-three~~] twenty-seven, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discreet groups as may be determined by the commissioner pursuant to regulations, shall be based on episodic payments. In establishing such payments, a statewide base price shall be established for each sixty day episode of care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

§ 14. Section 4 of chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, as amended by section 2 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 4. This act shall take effect 120 days after it shall have become a law and shall expire and be deemed repealed March 31, [~~2023~~] 2026.

§ 15. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 3 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal years beginning April first, two thousand twelve and April first, two thousand thirteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand fourteen, April first, two thousand fifteen and April first, two thousand sixteen and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand seventeen, April first,

two thousand eighteen, and April first, two thousand nineteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty, April first, two thousand twenty-one, and April first, two thousand twenty-two, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty-three, April first, two thousand twenty-four, and April first, two thousand twenty-five. The amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

§ 16. Section 18 of chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, as amended by section 4 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 18. This act shall take effect immediately, except that sections six, nine, ten and eleven of this act shall take effect on the sixtieth day after it shall have become a law, sections two, three, four and nine of this act shall expire and be of no further force or effect on or after March 31, [~~2023~~] 2026, section two of this act shall take effect on April 1, 1985 or seventy-five days following the submission of the report required by section one of this act, whichever is later, and sections eleven and thirteen of this act shall expire and be of no further force or effect on or after March 31, 1988.

§ 17. Section 4 of part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, as amended by section 5 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 4. This act shall take effect immediately[~~; provided that the provisions of section one of this act shall be deemed to have been in full force and effect on and after April 1, 2003, and shall expire March 31, 2023 when upon such date the provisions of such section shall be deemed repealed~~].

§ 18. Subdivision (o) of section 111 of part H of chapter 59 of the laws of 2011, amending the public health law relating to the statewide health information network of New York and the statewide planning and research cooperative system and general powers and duties, as amended by section 6 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

[~~(o) sections thirty-eight and thirty-eight-a of this act shall expire and be deemed repealed March 31, 2023;~~]

§ 19. Section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, as amended by section 7 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 32. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2008; provided however, that sections one, six-a, nineteen, twenty, twenty-four, and twenty-five of this act shall take effect July 1, 2008; provided however that sections sixteen, seventeen and eighteen of this act shall expire April 1, [~~2023~~] 2026; provided, however, that the amendments made by section twenty-eight of this act shall take effect on the same date as section 1 of chapter 281 of the laws of 2007 takes effect; provided further, that sections twenty-nine, thirty, and thirty-one of this act shall take effect October 1, 2008; provided further, that section twenty-seven of this act shall take effect January 1, 2009; and provided further, that section twenty-seven of this act shall expire and be deemed repealed March 31, [~~2023~~] 2026; and provided, further, however, that the amendments to subdivision 1 of section 241 of the education law made by section twenty-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided that the amendments to section 272 of the public health law made by section thirty of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

§ 20. Section 228 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 12 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

§ 228. 1. Definitions. (a) Regions, for purposes of this section, shall mean a downstate region to consist of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region to consist of all other New York state counties. A certified home health agency or long term home health care program shall be located in the same county utilized by the commissioner of health for the establishment of rates pursuant to article 36 of the public health law.

(b) Certified home health agency (CHHA) shall mean such term as defined in section 3602 of the public health law.

(c) Long term home health care program (LTHHCP) shall mean such term as defined in subdivision 8 of section 3602 of the public health law.

(d) Regional group shall mean all those CHHAs and LTHHCPs, respectively, located within a region.

(e) Medicaid revenue percentage, for purposes of this section, shall mean CHHA and LTHHCP revenues attributable to services provided to persons eligible for payments pursuant to title 11 of article 5 of the social services law divided by such revenues plus CHHA and LTHHCP revenues attributable to services provided to beneficiaries of Title XVIII of the federal social security act (medicare).

(f) Base period, for purposes of this section, shall mean calendar year 1995.

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall

mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 and the 2010 target period shall mean January 1, 2010 through November 30, 2010 and the 2011 target period shall mean January 1, 2011 through November 30, 2011 and the 2012 target period shall mean January 1, 2012 through November 30, 2012 and the 2013 target period shall mean January 1, 2013 through November 30, 2013, and the 2014 target period shall mean January 1, 2014 through November 30, 2014 and the 2015 target period shall mean January 1, 2015 through November 30, 2015 and the 2016 target period shall mean January 1, 2016 through November 30, 2016 and the 2017 target period shall mean January 1, 2017 through November 30, 2017 and the 2018 target period shall mean January 1, 2018 through November 30, 2018 and the 2019 target period shall mean January 1, 2019 through November 30, 2019 and the 2020 target period shall mean January 1, 2020 through November 30, 2020[~~,~~] and the 2021 target period shall mean January 1, 2021 through November 30, 2021 and the 2022 target period shall mean January 1, 2022 through November 30, 2022 and the 2023 target period shall mean January 1, 2023 through November 30, 2023 **and the 2024 target period shall mean January 1, 2024 through November 30, 2024 and the 2025 target period shall mean January 1, 2025 through November 30, 2025 and the 2026 target period shall mean January 1, 2026 through November 30, 2026 and the 2027 target period shall mean January 1, 2027 through November 30, 2027**.

2. (a) Prior to February 1, 1997, for each regional group the commissioner of health shall calculate the 1996 medicaid revenue percentages for the period commencing August 1, 1996 to the last date for which such data is available and reasonably accurate.

(b) Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012, prior to February 1, 2013, prior to February 1, 2014, prior to February 1, 2015, prior to February 1, 2016, prior to February 1, 2017, prior to February 1, 2018, prior to February 1, 2019, prior to February 1, 2020, prior to February 1, 2021, prior to February 1, 2022, [~~and~~] prior to February 1, 2023**, prior to February 1, 2024, prior to February 1, 2025, prior to February 1, 2026 and prior to February 1, 2027** for each regional group the commissioner of health shall calculate the prior year's medicaid revenue percentages for the period commencing January 1 through November 30 of such prior year.

3. By September 15, 1996, for each regional group the commissioner of health shall calculate the base period medicaid revenue percentage.

4. (a) For each regional group, the 1996 target medicaid revenue percentage shall be calculated by subtracting the 1996 medicaid revenue reduction percentages from the base period medicaid revenue percentages. The 1996 medicaid revenue reduction percentage, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025, 2026 and 2027** for each regional group, the target medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's medicaid revenue reduction percentage from the base period medicaid revenue percentage. The medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025, 2026 and 2027**, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to for each such year:

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.

(c) For each regional group, the 1999 target medicaid revenue percentage shall be calculated by subtracting the 1999 medicaid revenue reduction percentage from the base period medicaid revenue percentage. The 1999 medicaid revenue reduction percentages, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

(i) eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

(ii) forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

(iii) one and thirty-five hundredths percentage points (1.35) for LTHHCPs located within the downstate region; and

(iv) one and two hundred seventy-five thousandths percentage points (1.275) for LTHHCPs located within the upstate region.

5. (a) For each regional group, if the 1996 medicaid revenue percentage is not equal to or less than the 1996 target medicaid revenue percentage, the commissioner of health shall compare the 1996 medicaid revenue percentage to the 1996 target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the 1996 medicaid revenue reduction percentage, shall be called the 1996 reduction factor. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 medicaid revenue percentage is equal to or less than the 1996 target medicaid revenue percentage, the 1996 reduction factor shall be zero.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025, 2026 and 2027**, for each regional group, if the medicaid revenue percentage for the respective year is not equal to or less than the target medicaid revenue percentage for such respective year, the commissioner of health shall compare such respective year's medicaid revenue percentage to such respective year's target medicaid revenue percentage to determine the amount of the short-

fall which, when divided by the respective year's medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the medicaid revenue percentage for a particular year is equal to or less than the target medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

6. (a) For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount:

(i) two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars ($1,270,000) for LTHHCPs located within the downstate region; and

(iv) five hundred ninety thousand dollars ($590,000) for LTHHCPs located within the upstate region.

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025, 2026 and 2027**, for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

(i) two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars ($1,270,000) for LTHHCPs located within the downstate region; and

(iv) five hundred ninety thousand dollars ($590,000) for LTHHCPs located within the upstate region.

For each regional group reduction, if the reduction factor for a particular year shall be zero, there shall be no state share reduction amount for such year.

(c) For each regional group, the 1999 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

(i) one million seven hundred ninety-two thousand five hundred dollars ($1,792,500) for CHHAs located within the downstate region;

(ii) five hundred sixty-two thousand five hundred dollars ($562,500) for CHHAs located within the upstate region;

(iii) nine hundred fifty-two thousand five hundred dollars ($952,500) for LTHHCPs located within the downstate region; and

(iv) four hundred forty-two thousand five hundred dollars ($442,500) for LTHHCPs located within the upstate region.

For each regional group reduction, if the 1999 reduction factor shall be zero, there shall be no 1999 state share reduction amount.

7. (a) For each regional group, the 1996 state share reduction amount shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the 1996 target medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to

achieve the 1996 target medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount calculation pursuant to paragraph (a) of subdivision 6 of this section. This amount shall be called the 1996 provider specific state share reduction amount.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025, 2026 and 2027** for each regional group, the state share reduction amount for the respective year shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount calculation pursuant to paragraph (b) or (c) of subdivision 6 of this section. This amount shall be called the provider specific state share reduction amount for the applicable year.

8. (a) The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and LTHHCP and may be recouped by the state by March 31, 1997 in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

(b) The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025, 2026 and 2027** respectively, shall be due to the state from each CHHA and LTHHCP and each year the amount due for such year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

9. CHHAs and LTHHCPs shall submit such data and information at such times as the commissioner of health may require for purposes of this section. The commissioner of health may use data available from third-party payors.

10. On or about June 1, 1997, for each regional group the commissioner of health shall calculate for the period August 1, 1996 through March 31, 1997 a medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided in paragraph (a) of subdivision 2, paragraph (a) of subdivision 5, paragraph (a) of subdivision 6 and paragraph (a) of subdivision 7 of this section. The provider specific state share reduction amount calculated in accordance with this subdivision shall be compared to the 1996 provider specific state share reduction amount calculated in accordance with paragraph (a) of subdivision 7 of this section. Any amount in excess of the amount determined in accordance with paragraph (a) of subdivision 7 of this section shall be due to the state from each CHHA and LTHHCP and may be recouped in accordance with paragraph (a) of subdivision 8 of this section. If the amount is less than the amount determined in accordance with paragraph (a) of subdivision 7 of this section, the difference shall be refunded to the CHHA and LTHHCP by the state no later than July 15, 1997. CHHAs and LTHHCPs shall submit data for the period August 1, 1996 through March 31, 1997 to the commissioner of health by April 15, 1997.

11. If a CHHA or LTHHCP fails to submit data and information as required for purposes of this section:

(a) such CHHA or LTHHCP shall be presumed to have no decrease in medicaid revenue percentage between the applicable base period and the applicable target period for purposes of the calculations pursuant to this section; and

(b) the commissioner of health shall reduce the current rate paid to such CHHA and such LTHHCP by state governmental agencies pursuant to article 36 of the public health law by one percent for a period beginning on the first day of the calendar month following the applicable due date as established by the commissioner of health and continuing until the last day of the calendar month in which the required data and information are submitted.

12. The commissioner of health shall inform in writing the director of the budget and the chair of the senate finance committee and the chair of the assembly ways and means committee of the results of the calculations pursuant to this section.

§ 21. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 13 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, February 1, 2013, February 1, 2014, February 1, 2015, February 1, 2016, February 1, 2017, February 1, 2018, February 1, 2019, February 1, 2020, February 1, 2021, February 1, 2022 [~~and~~], February 1, 2023**, February 1, 2024, February 1, 2025 and February 1, 2026**, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025 and 2026** statewide target percentage respectively.

§ 22. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 14 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023**, 2024, 2025 and 2026** statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016,

2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024, 2025 and 2026 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024, 2025 and 2026 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

§ 23. Subparagraph (iii) of paragraph (b) of subdivision 4 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 15 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024, 2025 and 2026 statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024, 2025 and 2026 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024, 2025 and 2026 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019 2020, 2021, 2022 [~~and~~], 2023, 2024, 2025 and 2026 reduction amount.

§ 24. The opening paragraph of paragraph (e) of subdivision 7 of section 367-a of the social services law, as amended by section 1 of part GG of chapter 56 of the laws of 2020, is amended to read as follows:

During the period from April first, two thousand fifteen through March thirty-first, two thousand [~~twenty-three~~] twenty-six, the commissioner may, in lieu of a managed care provider or pharmacy benefit manager, negotiate directly and enter into an arrangement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title and may also negotiate directly and enter into such an agreement relating to pharmaceutical utilization by medical assistance recipients not so enrolled. Such rebate arrangements shall be limited to the following: antiretrovirals approved by the FDA for the treatment of HIV/AIDS, opioid dependence agents and opioid antagonists listed in a statewide formulary established pursuant to subparagraph (vii) of this paragraph, hepatitis C agents, high cost drugs as provided for in subparagraph (viii) of this paragraph, gene therapies as provided for in subparagraph (ix) of this paragraph, and any other class or drug designated by the commissioner for which the pharmaceutical manufacturer has in effect a rebate arrangement with the federal secretary of health and human services pursuant to 42 U.S.C. § 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond the expiration or repeal of this paragraph.

§ 25. Subdivision 1 of section 60 of part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to

supplemental rebates, as amended by section 8 of part GG of chapter 56 of the laws of 2020, is amended to read as follows:

1. section one of this act shall expire and be deemed repealed March 31, [~~2026~~] 2029;

§ 26. Section 8 of part KK of chapter 56 of the laws of 2020, amending the public health law relating to the designation of statewide general hospital quality and sole community pools and the reduction of capital related inpatient expenses, is amended to read as follows:

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2020, provided, further that sections [~~three~~] four through [~~nine~~] seven of this act shall expire and be deemed repealed March 31, [~~2023~~] 2026; provided further, however, that the director of the budget may, in consultation with the commissioner of health, delay the effective dates prescribed herein for a period of time which shall not exceed ninety days following the conclusion or termination of an executive order issued pursuant to section 28 of the executive law declaring a state disaster emergency for the entire state of New York, upon such delay the director of budget shall notify the chairs of the assembly ways and means committee and senate finance committee and the chairs of the assembly and senate health committee; provided further, however, that the director of the budget shall notify the legislative bill drafting commission upon the occurrence of a delay in the effective date of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

§ 27. Subdivision 4-a of section 71 of part C of chapter 60 of the laws of 2014, amending the social services law relating to fair hearings within the Fully Integrated Duals Advantage program, as amended by section 7 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

4-a. section twenty-two of this act shall take effect April 1, 2014, and shall be deemed expired January 1, [~~2024~~] 2027;

§ 28. Section 4 of chapter 779 of the laws of 1986, amending the social services law relating to authorizing services for non-residents in adult homes, residences for adults and enriched housing programs, as amended by section 1 of item PP of subpart B of part XXX of chapter 58 of the laws of 2020, is amended to read as follows:

§ 4. This act shall take effect on the one hundred twentieth day after it shall have become a law and shall remain in full force and effect until July 1, [~~2023~~] 2027, provided however, that effective immediately, the addition, amendment and/or repeal of any rules or regulations neces-sary for the implementation of the foregoing sections of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

§ 29. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 1 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

§ 11. This act shall take effect immediately and:

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

(b) sections four through ten shall expire on June 30, [~~2023~~] 2025, and

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

§ 30. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 3 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023**, and on and after April 1, 2023 through March 31, 2027**;

§ 31. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 4 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

§ 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023**, and on and after April 1, 2023 through March 31, 2027**.

§ 32. Section 4-a of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 5 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2017 through March 31, [~~2023~~] **2025**, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social

services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024 and 2025 calendar years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024 and 2025 calendar years shall also be applied to rates of payment provided on and after January 1, 2017 through March 31, [~~2023~~] 2025 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations; and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2017 through March 31, [~~2023~~] 2025, such trend factors attributable to the 2017, 2018, 2019, 2020, 2021, 2022 [~~and~~], 2023, 2024 and 2025 calendar years shall be established at no greater than zero percent.

§ 33. Subdivision 2 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 6 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, 2015 and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023, and on and after April 1, 2023 through March 31, 2025;

§ 34. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 11 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

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

further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand nineteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand nineteen through March thirty-first, two thousand twenty-one such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand twenty-one through March thirty-first, two thousand twenty-three such assessment shall be six percent**, and further provided that for all such gross receipts received on or after April first, two thousand twenty-three through March thirty-first, two thousand twenty-five such assessment shall be six percent**.

§ 35. Section 3 of part MM of chapter 57 of the laws of 2021 amending the public health law relating to aiding in the transition to adulthood for children with medical fragility living in pediatric nursing homes and other settings is amended to read as follows:

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

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

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

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

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

§ 36. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023; provided, however, that the amendments to subdivision 6 of section 366 of the social services law made by section four of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith; provided further, however, that the amendments to subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law made by section ten of this act shall not affect the expiration of such subparagraph and shall be deemed to expire therewith; and provided further, however, that the amendments to the opening paragraph of para-

graph (e) of subdivision 7 of section 367-a of the social services law made by section twenty-four of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; provided further, that the amendments to section 364-j of the social services law made by section thirty-five-a of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART C

Section 1. Section 34 of part A3 of chapter 62 of the laws of 2003 amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, as amended by section 1 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

§ 34. (1) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the state comptroller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated pursuant to section 2807-v of the public health law, including income from invested funds, for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by section 2807-v of the public health law.

(2) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the state comptroller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated and interest earned through surcharges on payments for health care services pursuant to section 2807-s of the public health law and from assessments pursuant to section 2807-t of the public health law for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by sections 2807-s, 2807-t, and 2807-m of the public health law.

(3) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of paragraph (a) of subdivision 1 of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to the child health insurance plan program authorized pursuant to title 1-A of article 25 of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, child health insurance account, established within the department of health.

(5) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those

funds allocated pursuant to paragraph (j) of subdivision 1 of section 2807-v of the public health law for the purpose of payment for administrative costs of the department of health related to administration of the state's tobacco control programs and cancer services provided pursuant to sections 2807-r and 1399-ii of the public health law into such accounts established within the department of health for such purposes.

(6) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, the funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to the programs funded pursuant to section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, pilot health insurance account, established within the department of health.

(7) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of subparagraph (ii) of paragraph (f) of subdivision 19 of section 2807-c of the public health law from monies accumulated and interest earned in the bad debt and charity care and capital statewide pools through an assessment charged to general hospitals pursuant to the provisions of subdivision 18 of section 2807-c of the public health law and those funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, primary care initiatives account, established within the department of health.

(8) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, health care delivery administration account, established within the department of health.

(9) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [~~2023~~] 2026, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized pursuant to sections 2807-d, 3614-a and 3614-b of the public health law and section 367-i of the social services law and for distribution in accordance with the provisions of subdivision 9 of section 2807-j of the public health law for the purpose of payment for administration of statutory duties for the collections and distributions authorized by sections 2807-c, 2807-d, 2807-j, 2807-k, 2807-l, 3614-a and 3614-b of the public health law and section 367-i of the social

services law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, established within the department of health.

§ 2. Subparagraphs (iv) and (v) of paragraph (a) of subdivision 9 of section 2807-j of the public health law, as amended by section 2 of part Y of chapter 56 of the laws of 2020, are amended to read as follows:

(iv) seven hundred sixty-five million dollars annually of the funds accumulated for the periods January first, two thousand through December thirty-first, two thousand [~~twenty-two~~] twenty five, and

(v) one hundred ninety-one million two hundred fifty thousand dollars of the funds accumulated for the period January first, two thousand [~~twenty-three~~] twenty-six through March thirty-first, two thousand [~~twenty-three~~] twenty-six.

§ 3. Subdivision 5 of section 168 of chapter 639 of the laws of 1996, constituting the New York Health Care Reform Act of 1996, as amended by section 3 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

5. sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, as amended or as added by this act, shall expire on December 31, [~~2023~~] 2026, and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s and 2807-t of the public health law related to patient services provided before December 31, [~~2023~~] 2026, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

§ 4. Subdivision 1 of section 138 of chapter 1 of the laws of 1999, constituting the New York Health Care Reform Act of 2000, as amended by section 4 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

1. sections 2807-c, 2807-j, 2807-s, and 2807-t of the public health law, as amended by this act, shall expire on December 31, [~~2023~~] 2026, and shall be thereafter effective only in respect to any act done before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s, 2807-t, 2807-v and 2807-w of the public health law, as amended or added by this act, related to patient services provided before December 31, [~~2023~~] 2026, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

§ 5. Section 2807-l of the public health law, as amended by section 5 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

§ 2807-l. Health care initiatives pool distributions. 1. Funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, or the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed

or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following.

(a) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions to programs to provide health care coverage for uninsured or underinsured children pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter from the respective health care initiatives pools established for the following periods in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to one hundred twenty million six hundred thousand dollars;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, up to one hundred sixty-four million five hundred thousand dollars;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to one hundred eighty-one million dollars;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand, two hundred seven million dollars;

(v) from the pool for the period January first, two thousand one through December thirty-first, two thousand one, two hundred thirty-five million dollars;

(vi) from the pool for the period January first, two thousand two through December thirty-first, two thousand two, three hundred twenty-four million dollars;

(vii) from the pool for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred fifty million three hundred thousand dollars;

(viii) from the pool for the period January first, two thousand four through December thirty-first, two thousand four, up to four hundred sixty million nine hundred thousand dollars;

(ix) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand five, up to one hundred fifty-three million eight hundred thousand dollars;

(x) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to three hundred twenty-five million four hundred thousand dollars;

(xi) from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred twenty-eight million fifty-nine thousand dollars;

(xii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, up to four hundred fifty-three million six hundred seventy-four thousand dollars annually;

(xiii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, up to one hundred thirteen million four hundred eighteen thousand dollars;

(xiv) from the health care reform act (HCRA) resources fund for the period April first, two thousand eleven, through March thirty-first, two

thousand twelve, up to three hundred twenty-four million seven hundred forty-four thousand dollars;

(xv) from the health care reform act (HCRA) resources fund for the period April first, two thousand twelve, through March thirty-first, two thousand thirteen, up to three hundred forty-six million four hundred forty-four thousand dollars;

(xvi) from the health care reform act (HCRA) resources fund for the period April first, two thousand thirteen, through March thirty-first, two thousand fourteen, up to three hundred seventy million six hundred ninety-five thousand dollars; and

(xvii) from the health care reform act (HCRA) resources fund for each state fiscal year for periods on and after April first, two thousand fourteen, within amounts appropriated.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions for health insurance programs under the individual subsidy programs established pursuant to the expanded health care coverage act of nineteen hundred eighty-eight as amended, and for evaluation of such programs from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following amounts:

(i) (A) an amount not to exceed six million dollars on an annualized basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine; up to six million dollars for the period January first, two thousand through December thirty-first, two thousand; up to five million dollars for the period January first, two thousand one through December thirty-first, two thousand one; up to four million dollars for the period January first, two thousand two through December thirty-first, two thousand two; up to two million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three; up to one million three hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four; up to six hundred seventy thousand dollars for the period January first, two thousand five through June thirtieth, two thousand five; up to one million three hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven; and up to one million three hundred thousand dollars annually for the period April first, two thousand seven through March thirty-first, two thousand nine, shall be allocated to individual subsidy programs; and

(B) an amount not to exceed seven million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and four million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, and three million dollars for the period January first, two thousand three through December thirty-first, two thousand three, and two million dollars for the period January first, two thousand four through December thirty-first, two thousand four, and two million dollars for the period January first, two thousand five through June thirtieth, two thousand five shall be allocated to the catastrophic health care expense program.

(ii) Notwithstanding any law to the contrary, the characterizations of the New York state small business health insurance partnership program as in effect prior to June thirtieth, two thousand three, voucher program as in effect prior to December thirty-first, two thousand one,

individual subsidy program as in effect prior to June thirtieth, two thousand five, and catastrophic health care expense program, as in effect prior to June thirtieth, two thousand five, may, for the purposes of identifying matching funds for the community health care conversion demonstration project described in a waiver of the provisions of title XIX of the federal social security act granted to the state of New York and dated July fifteenth, nineteen hundred ninety-seven, may continue to be used to characterize the insurance programs in sections four thousand three hundred twenty-one-a, four thousand three hundred twenty-two-a, four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law, which are successor programs to these programs.

(c) Up to seventy-eight million dollars shall be reserved and accumulated from year to year from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, for purposes of public health programs, up to seventy-six million dollars shall be reserved and accumulated from year to year from the pools for the periods January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to eighty-four million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand through December thirty-first, two thousand, up to eighty-five million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand one through December thirty-first, two thousand one, up to eighty-six million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand two through December thirty-first, two thousand two, up to eighty-six million one hundred fifty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand three through December thirty-first, two thousand three, up to fifty-eight million seven hundred eighty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand four through December thirty-first, two thousand four, up to sixty-eight million seven hundred thirty thousand dollars shall be reserved and accumulated from year to year from the pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand five, up to ninety-four million three hundred fifty thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to seventy million nine hundred thirty-nine thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to fifty-five million six hundred eighty-nine thousand dollars annually shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, up to thirteen million nine hundred twenty-two thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and for periods on and after April first, two thousand

eleven, up to funding amounts specified below and shall be available, including income from invested funds, for:

(i) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the department of health's special revenue fund - other, hospital based grants program account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of services and expenses related to general hospital based grant programs, up to twenty-two million dollars annually from the nineteen hundred ninety-seven pool, nineteen hundred ninety-eight pool, nineteen hundred ninety-nine pool, two thousand pool, two thousand one pool and two thousand two pool, respectively, up to twenty-two million dollars from the two thousand three pool, up to ten million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to eleven million dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-two million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty-two million ninety-seven thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to five million five hundred twenty-four thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to thirteen million four hundred forty-five thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, and up to thirteen million three hundred seventy-five thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen;

(ii) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the emergency medical services training account established in section ninety-seven-q of the state finance law or the health care reform act (HCRA) resources fund, whichever is applicable, up to sixteen million dollars on an annualized basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, up to twenty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to twenty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one, up to twenty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to twenty-two million five hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to nine million six hundred eighty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million one hundred thirty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-four million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty million four hundred ninety-two thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to five million one hundred twenty-three thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to eighteen million three hundred fifty thousand dollars for the period April first, two thousand eleven

through March thirty-first, two thousand twelve, up to eighteen million nine hundred fifty thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to nineteen million four hundred nineteen thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, and up to nineteen million six hundred fifty-nine thousand seven hundred dollars each state fiscal year for the period of April first, two thousand fourteen through March thirty-first, two thousand [~~twenty-three~~] twenty-six;

(iii) priority distributions by the commissioner up to thirty-two million dollars on an annualized basis for the period January first, two thousand through December thirty-first, two thousand four, up to thirty-eight million dollars on an annualized basis for the period January first, two thousand five through December thirty-first, two thousand six, up to eighteen million two hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to three million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, up to seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, and up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~twenty-three~~] twenty-six to be allocated (A) for the purposes established pursuant to subparagraph (ii) of paragraph (f) of subdivision nineteen of section twenty-eight hundred seven-c of this article as in effect on December thirty-first, nineteen hundred ninety-six and as may thereafter be amended, up to fifteen million dollars annually for the periods January first, two thousand through December thirty-first, two thousand four, up to twenty-one million dollars annually for the period January first, two thousand five through December thirty-first, two thousand six, and up to seven million five hundred thousand dollars for the period January first, two thousand seven through March thirty-first, two thousand seven;

(B) pursuant to a memorandum of understanding entered into by the commissioner, the majority leader of the senate and the speaker of the assembly, for the purposes outlined in such memorandum upon the recommendation of the majority leader of the senate, up to eight million five hundred thousand dollars annually for the period January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, and for the purposes outlined in such memorandum upon the recommendation of the speaker of the assembly, up to eight million five hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven; and

(C) for services and expenses, including grants, related to emergency assistance distributions as designated by the commissioner. Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other contrary provision of law, such distributions shall be limited to providers or programs where, as determined by the commissioner, emergency assistance is vital to protect the life or

safety of patients, to ensure the retention of facility caregivers or other staff, or in instances where health facility operations are jeopardized, or where the public health is jeopardized or other emergency situations exist, up to three million dollars annually for the period April first, two thousand seven through March thirty-first, two thousand eleven, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**, and up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six**. Upon any distribution of such funds, the commissioner shall immediately notify the chair and ranking minority member of the senate finance committee, the assembly ways and means committee, the senate committee on health, and the assembly committee on health;

(iv) distributions by the commissioner related to poison control centers pursuant to subdivision seven of section twenty-five hundred-d of this chapter, up to five million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to three million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-nine, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four million six hundred thousand dollars annually for the periods January first, two thousand three through December thirty-first, two thousand four, up to five million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand six annually, up to five million one hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand nine, up to three million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to seven hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to two million five hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to three million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to three million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to three million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**, and up to three million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six**; and

(v) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for

deposit to, to the credit of the department of health's special revenue fund - other, miscellaneous special revenue fund - 339 maternal and child HIV services account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of a special program for HIV services for women and children, including adolescents pursuant to section twenty-five hundred-f-one of this chapter, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to two million five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to two million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to five million dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and up to five million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(d) (i) An amount of up to twenty million dollars annually for the period January first, two thousand through December thirty-first, two thousand six, up to ten million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, up to twenty million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, up to five million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to nineteen million six hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to nineteen million six hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to nineteen million six hundred thousand dollars each state fiscal year for the period of April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to nineteen million six hundred thousand dollars each state fiscal year for the period of April first, two thousand twenty through March thirty-first, two thousand twenty-three**, and up to nineteen million six hundred thousand dollars each state fiscal year for the period of April first, two thousand twenty-three through March thirty-first, two thousand twenty-six**, shall be transferred to the health facility restructuring pool established pursuant to section twenty-eight hundred fifteen of this article;

(ii) provided, however, amounts transferred pursuant to subparagraph (i) of this paragraph may be reduced in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to the health facility restructuring program.

(f) Funds shall be accumulated and transferred from as follows:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, (A) thirty-four million six hundred thousand dollars shall be transferred to funds reserved and accumulated pursuant to paragraph (b) of subdivision nineteen of section twenty-eight hundred seven-c of this

article, and (B) eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iv) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand through December thirty-first, two thousand four, eighty-two million dollars annually, and for the period January first, two thousand five through December thirty-first, two thousand five, eighty-two million dollars, and for the period January first, two thousand six through December thirty-first, two thousand six, eighty-two million dollars, and for the period January first, two thousand seven through December thirty-first, two thousand seven, eighty-two million dollars, and for the period January first, two thousand eight through December thirty-first, two thousand eight, ninety million seven hundred thousand dollars shall be deposited by the commissioner, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account;

(v) from the health care reform act (HCRA) resources fund for the period January first, two thousand nine through December thirty-first, two thousand nine, one hundred eight million nine hundred seventy-five thousand dollars, and for the period January first, two thousand ten through December thirty-first, two thousand ten, one hundred twenty-six million one hundred thousand dollars, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, twenty million five hundred thousand dollars, and for each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, one hundred forty-six million four hundred thousand dollars, shall be deposited by the commissioner, and the state comptroller is hereby authorized and directed to receive for deposit, to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account.

(g) Funds shall be transferred to primary health care services pools created by the commissioner, and shall be available, including income from invested funds, for distributions in accordance with former section twenty-eight hundred seven-bb of this article from the respective health care initiatives pools for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, fifteen and eighty-seven-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, fifteen and eighty-seven-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, sixteen and thirteen-hundredths percent.

(h) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for purposes of primary care education and training pursuant to article nine of this chapter from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision and shall be available for distributions as follows:

(i) funds shall be reserved and accumulated:

(A) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(B) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(C) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(ii) funds shall be available for distributions including income from invested funds as follows:

(A) for purposes of the primary care physician loan repayment program in accordance with section nine hundred three of this chapter, up to five million dollars on an annualized basis;

(B) for purposes of the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter, up to two million dollars on an annualized basis;

(C) for purposes of minority participation in medical education grants in accordance with section nine hundred six of this chapter, up to one million dollars on an annualized basis; and

(D) provided, however, that the commissioner may reallocate any funds remaining or unallocated for distributions for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for distributions in accordance with section twenty-nine hundred fifty-two and section twenty-nine hundred fifty-eight of this chapter for rural health care delivery development and rural health care access development, respectively, from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirteen and forty-nine-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirteen and forty-nine-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirteen and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, seventeen million dollars annually, and for the period January first, two thousand three through December thirty-first, two thousand three, up to fifteen million eight hundred fifty thousand dollars;

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand four through December thirty-first, two thousand four, up to fifteen million eight hundred fifty thousand dollars, for the period January first, two thousand five through December thirty-first, two thousand five, up to nineteen million two hundred thousand dollars, for the period January first, two thousand six through December thirty-first, two thousand six, up to nineteen million two hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to eighteen million one hundred fifty thousand dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million five hundred thirty-eight thousand dollars, for each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to sixteen million two hundred thousand dollars, up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**, and up to sixteen million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six**.

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions related to health information and health care quality improvement pursuant to former section twenty-eight hundred seven-n of this article from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent.

(k) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for allocations and distributions in accordance with section twenty-eight hundred seven-p of this article for diagnostic and treatment center uncompensated care from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a)

through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirty-eight and one-tenth percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirty-eight and one-tenth percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirty-eight and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, forty-eight million dollars annually, and for the period January first, two thousand three through June thirtieth, two thousand three, twenty-four million dollars;

(v) (A) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period July first, two thousand three through December thirty-first, two thousand three, up to six million dollars, for the period January first, two thousand four through December thirty-first, two thousand six, up to twelve million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand thirteen, up to forty-eight million dollars annually, for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen, up to twelve million dollars for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to forty-eight million dollars annually, for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to forty-eight million dollars annually, [~~and~~] for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, up to forty-eight million dollars annually**, and for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, up to forty-eight million dollars annually**;

(B) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, an additional seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand thirteen, an additional seven million five hundred thousand dollars annually, for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen, an additional one million eight hundred seventy-five thousand dollars, for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, an additional seven million five hundred thousand dollars annually, for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, an additional seven million five hundred thousand dollars annually, [~~and~~] for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, an additional seven million five hundred thousand dollars annually**, and for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, an additional seven million five hundred thousand dollars annually** for voluntary non-profit diagnostic and treatment center uncompensated care in accordance with subdivision four-c of section twenty-eight hundred seven-p of this article; and

(vi) funds reserved and accumulated pursuant to this paragraph for periods on and after July first, two thousand three, shall be deposited

by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, for purposes of funding the state share of rate adjustments made pursuant to section twenty-eight hundred seven-p of this article, provided, however, that in the event federal financial participation is not available for rate adjustments made pursuant to paragraph (b) of subdivision one of section twenty-eight hundred seven-p of this article, funds shall be distributed pursuant to paragraph (a) of subdivision one of section twenty-eight hundred seven-p of this article from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable.

(l) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for transfer to and allocation for services and expenses for the payment of benefits to recipients of drugs under the AIDS drug assistance program (ADAP) - HIV uninsured care program as administered by Health Research Incorporated from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, nine and fifty-two-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, nine and fifty-two-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, nine and sixty-eight-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, up to twelve million dollars annually, and for the period January first, two thousand three through December thirty-first, two thousand three, up to forty million dollars; and

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the periods January first, two thousand four through December thirty-first, two thousand four, up to fifty-six million dollars, for the period January first, two thousand five through December thirty-first, two thousand six, up to sixty million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to sixty million dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fifteen million dollars, each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to forty-two million three hundred thousand dollars and up to forty-one million fifty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand [~~twenty-three~~] twenty-six.

(m) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions pursuant to section twenty-eight hundred seven-r of

this article for cancer related services from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, seven and ninety-four-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, seven and ninety-four-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand two, up to ten million dollars on an annual basis;

(v) from the pool for the period January first, two thousand three through December thirty-first, two thousand four, up to eight million nine hundred fifty thousand dollars on an annual basis;

(vi) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand six, up to ten million fifty thousand dollars on an annual basis, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to nineteen million dollars annually, and for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million seven hundred fifty thousand dollars.

(n) Funds shall be accumulated and transferred from the health care reform act (HCRA) resources fund as follows: for the period April first, two thousand seven through March thirty-first, two thousand eight, and on an annual basis for the periods April first, two thousand eight through November thirtieth, two thousand nine, funds within amounts appropriated shall be transferred and deposited and credited to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, for purposes of funding the state share of rate adjustments made to public and voluntary hospitals in accordance with paragraphs (i) and (j) of subdivision one of section twenty-eight hundred seven-c of this article.

2. Notwithstanding any inconsistent provision of law, rule or regulation, any funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, as a result of surcharges, assessments or other obligations during the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, which are unused or uncommitted for distributions pursuant to this section shall be reserved and accumulated from year to year by the commissioner and, within amounts appropriated, transferred and deposited into the special revenue funds - other, miscellaneous special revenue fund - 339, child health insurance account or any successor fund or account, for purposes of distributions to implement the child health insurance program established pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter for periods on and after January first, two thousand one; provided, however, funds reserved

and accumulated for priority distributions pursuant to subparagraph (iii) of paragraph (c) of subdivision one of this section shall not be transferred and deposited into such account pursuant to this subdivision; and provided further, however, that any unused or uncommitted pool funds accumulated and allocated pursuant to paragraph (j) of subdivision one of this section shall be distributed for purposes of the health information and quality improvement act of 2000.

3. Revenue from distributions pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

§ 6. Subdivision 5-a of section 2807-m of the public health law, as amended by section 6 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

5-a. Graduate medical education innovations pool. (a) Supplemental distributions. (i) Thirty-one million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York as in effect on January first, two thousand eight; provided, however, for purposes of funding the empire clinical research investigation program (ECRIP) in accordance with paragraph eight of subdivision (e) and paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York, distributions shall be made using two regions defined as New York city and the rest of the state and the dollar amount set forth in subparagraph (i) of paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be increased from sixty thousand dollars to seventy-five thousand dollars.

(ii) For periods on and after January first, two thousand nine, supplemental distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall no longer be made and the provisions of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be null and void.

(b) Empire clinical research investigator program (ECRIP). Nine million one hundred twenty thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and two million two hundred eighty thousand dollars for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, nine million one hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty,

[~~and~~] up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, **and up to eight million six hundred twelve thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six,** shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section to be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding going to the rest of the state and shall be available for distribution as follows:

Distributions shall first be made to consortia and teaching general hospitals for the empire clinical research investigator program (ECRIP) to help secure federal funding for biomedical research, train clinical researchers, recruit national leaders as faculty to act as mentors, and train residents and fellows in biomedical research skills based on hospital-specific data submitted to the commissioner by consortia and teaching general hospitals in accordance with clause (G) of this subparagraph. Such distributions shall be made in accordance with the following methodology:

(A) The greatest number of clinical research positions for which a consortium or teaching general hospital may be funded pursuant to this subparagraph shall be one percent of the total number of residents training at the consortium or teaching general hospital on July first, two thousand eight for the period January first, two thousand nine through December thirty-first, two thousand nine rounded up to the nearest one position.

(B) Distributions made to a consortium or teaching general hospital shall equal the product of the total number of clinical research positions submitted by a consortium or teaching general hospital and accepted by the commissioner as meeting the criteria set forth in paragraph (b) of subdivision one of this section, subject to the reduction calculation set forth in clause (C) of this subparagraph, times one hundred ten thousand dollars.

(C) If the dollar amount for the total number of clinical research positions in the region calculated pursuant to clause (B) of this subparagraph exceeds the total amount appropriated for purposes of this paragraph, including clinical research positions that continue from and were funded in prior distribution periods, the commissioner shall eliminate one-half of the clinical research positions submitted by each consortium or teaching general hospital rounded down to the nearest one position. Such reduction shall be repeated until the dollar amount for the total number of clinical research positions in the region does not exceed the total amount appropriated for purposes of this paragraph. If the repeated reduction of the total number of clinical research positions in the region by one-half does not render a total funding amount that is equal to or less than the total amount reserved for that region within the appropriation, the funding for each clinical research position in that region shall be reduced proportionally in one thousand dollar increments until the total dollar amount for the total number of clinical research positions in that region does not exceed the total amount reserved for that region within the appropriation. Any reduction in funding will be effective for the duration of the award. No clinical research positions that continue from and were funded in prior distribution periods shall be eliminated or reduced by such methodology.

(D) Each consortium or teaching general hospital shall receive its annual distribution amount in accordance with the following:

(I) Each consortium or teaching general hospital with a one-year ECRIP award shall receive its annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(II) Each consortium or teaching general hospital with a two-year ECRIP award shall receive its first annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. Each consortium or teaching general hospital will receive its second annual distribution amount in full upon completion of the requirements set forth in item (III) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(E) Each consortium or teaching general hospital receiving distributions pursuant to this subparagraph shall reserve seventy-five thousand dollars to primarily fund salary and fringe benefits of the clinical research position with the remainder going to fund the development of faculty who are involved in biomedical research, training and clinical care.

(F) Undistributed or returned funds available to fund clinical research positions pursuant to this paragraph for a distribution period shall be available to fund clinical research positions in a subsequent distribution period.

(G) In order to be eligible for distributions pursuant to this subparagraph, each consortium and teaching general hospital shall provide to the commissioner by July first of each distribution period, the following data and information on a hospital-specific basis. Such data and information shall be certified as to accuracy and completeness by the chief executive officer, chief financial officer or chair of the consortium governing body of each consortium or teaching general hospital and shall be maintained by each consortium and teaching general hospital for five years from the date of submission:

(I) For each clinical research position, information on the type, scope, training objectives, institutional support, clinical research experience of the sponsor-mentor, plans for submitting research outcomes to peer reviewed journals and at scientific meetings, including a meeting sponsored by the department, the name of a principal contact person responsible for tracking the career development of researchers placed in clinical research positions, as defined in paragraph (c) of subdivision one of this section, and who is authorized to certify to the commissioner that all the requirements of the clinical research training objectives set forth in this subparagraph shall be met. Such certification shall be provided by July first of each distribution period;

(II) For each clinical research position, information on the name, citizenship status, medical education and training, and medical license number of the researcher, if applicable, shall be provided by December thirty-first of the calendar year following the distribution period;

(III) Information on the status of the clinical research plan, accomplishments, changes in research activities, progress, and performance of the researcher shall be provided upon completion of one-half of the award term;

(IV) A final report detailing training experiences, accomplishments, activities and performance of the clinical researcher, and data, methods, results and analyses of the clinical research plan shall be provided three months after the clinical research position ends; and

(V) Tracking information concerning past researchers, including but not limited to (A) background information, (B) employment history, (C) research status, (D) current research activities, (E) publications and presentations, (F) research support, and (G) any other information necessary to track the researcher; and

(VI) Any other data or information required by the commissioner to implement this subparagraph.

(H) Notwithstanding any inconsistent provision of this subdivision, for periods on and after April first, two thousand thirteen, ECRIP grant awards shall be made in accordance with rules and regulations promulgated by the commissioner. Such regulations shall, at a minimum:

(1) provide that ECRIP grant awards shall be made with the objective of securing federal funding for biomedical research, training clinical researchers, recruiting national leaders as faculty to act as mentors, and training residents and fellows in biomedical research skills;

(2) provide that ECRIP grant applicants may include interdisciplinary research teams comprised of teaching general hospitals acting in collaboration with entities including but not limited to medical centers, hospitals, universities and local health departments;

(3) provide that applications for ECRIP grant awards shall be based on such information requested by the commissioner, which shall include but not be limited to hospital-specific data;

(4) establish the qualifications for investigators and other staff required for grant projects eligible for ECRIP grant awards; and

(5) establish a methodology for the distribution of funds under ECRIP grant awards.

(c) Physician loan repayment program. One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, one million nine hundred sixty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, **and up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six,** shall be set aside and reserved

by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician loan repayment in accordance with subdivision ten of this section. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance 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 proposal process as follows:

(i) Funding shall first be awarded to repay loans of up to twenty-five physicians who train in primary care or specialty tracks in teaching general hospitals, and who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to repay loans of physicians who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner, including but not limited to physicians working in general hospitals, or other health care facilities.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed in accordance with subparagraphs (i) and (ii) of this paragraph to physicians identified by general hospitals.

(iv) In addition to the funds allocated under this paragraph, for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(v) In addition to the funds allocated under this paragraph, for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(vi) Notwithstanding any provision of law to the contrary, and subject to the extension of the Health Care Reform Act of 1996, sufficient funds shall be available for the purposes described in subdivision ten of this section in amounts necessary to fund the remaining year commitments for awards made pursuant to subparagraphs (iv) and (v) of this paragraph.

(d) Physician practice support. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four million three hundred sixty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to four million three hundred sixty thousand dollars for each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, **and up to four million three hundred sixty thousand dollars for each fiscal**

year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician practice support. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance 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 proposal process as follows:

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by physicians trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to physicians to support the cost of establishing or joining practices in underserved communities, as determined by the commissioner, and to hospitals and other health care providers to recruit new physicians to provide services in underserved communities, as determined by the commissioner.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed to general hospitals in accordance with subparagraphs (i) and (ii) of this paragraph.

(e) Work group. For funding available pursuant to paragraphs (c) [and], (d) and (e) of this subdivision:

(i) The department shall appoint a work group from recommendations made by associations representing physicians, general hospitals and other health care facilities to develop a streamlined application process by June first, two thousand twelve.

(ii) Subject to available funding, applications shall be accepted on a continuous basis. The department shall provide technical assistance to applicants to facilitate their completion of applications. An applicant shall be notified in writing by the department within ten days of receipt of an application as to whether the application is complete and if the application is incomplete, what information is outstanding. The department shall act on an application within thirty days of receipt of a complete application.

(f) Study on physician workforce. Five hundred ninety thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, one hundred forty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, five hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to four hundred eighty-seven thousand dollars for each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [and] up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to four hundred eighty-seven thousand dollars each state fiscal year for the period April first, two thousand

twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available to fund a study of physician workforce needs and solutions including, but not limited to, an analysis of residency programs and projected physician workforce and community needs. The commissioner shall enter into agreements with one or more organizations to conduct such study based on a request for proposal process.

(g) Diversity in medicine/post-baccalaureate program. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, one million nine hundred sixty thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, **and up to one million six hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six,** shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the Associated Medical Schools of New York to fund its diversity program including existing and new post-baccalaureate programs for minority and economically disadvantaged students and encourage participation from all medical schools in New York. The associated medical schools of New York shall report to the commissioner on an annual basis regarding the use of funds for such purpose in such form and manner as specified by the commissioner.

(h) In the event there are undistributed funds within amounts made available for distributions pursuant to this subdivision, such funds may be reallocated and distributed in current or subsequent distribution periods in a manner determined by the commissioner for any purpose set forth in this subdivision.

§ 7. Subdivision 4-c of section 2807-p of the public health law, as amended by section 10 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

4-c. Notwithstanding any provision of law to the contrary, the commissioner shall make additional payments for uncompensated care to voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, in the amount of seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven, seven million five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight, seven million five hundred thousand dollars, for the period January first, two

thousand nine through December thirty-first, two thousand nine, fifteen million five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten, seven million five hundred thousand dollars, for the period January first, two thousand eleven though December thirty-first, two thousand eleven, seven million five hundred thousand dollars, for the period January first, two thousand twelve through December thirty-first, two thousand twelve, seven million five hundred thousand dollars, for the period January first, two thousand thirteen through December thirty-first, two thousand thirteen, seven million five hundred thousand dollars, for the period January first, two thousand fourteen through December thirty-first, two thousand fourteen, seven million five hundred thousand dollars, for the period January first, two thousand fifteen through December thirty-first, two thousand fifteen, seven million five hundred thousand dollars, for the period January first two thousand sixteen through December thirty-first, two thousand sixteen, seven million five hundred thousand dollars, for the period January first, two thousand seventeen through December thirty-first, two thousand seventeen, seven million five hundred thousand dollars, for the period January first, two thousand eighteen through December thirty-first, two thousand eighteen, seven million five hundred thousand dollars, for the period January first, two thousand nineteen through December thirty-first, two thousand nineteen, seven million five hundred thousand dollars, for the period January first, two thousand twenty through December thirty-first, two thousand twenty, seven million five hundred thousand dollars, for the period January first, two thousand twenty-one through December thirty-first, two thousand twenty-one, seven million five hundred thousand dollars, for the period January first, two thousand twenty-two through December thirty-first, two thousand twenty-two, seven million five hundred thousand dollars, **for the period January first, two thousand twenty-three through December thirty-first, two thousand twenty-three, seven million five hundred thousand dollars, for the period January first, two thousand twenty-four through December thirty-first, two thousand twenty-four, seven million five hundred thousand dollars, for the period January first, two thousand twenty-five through December thirty-first, two thousand twenty-five, seven million five hundred thousand dollars,** and for the period January first, two thousand [~~twenty-three~~] **twenty-six** through March thirty-first, two thousand [~~twenty-three~~] **twenty-six**, in the amount of one million six hundred thousand dollars, provided, however, that for periods on and after January first, two thousand eight, such additional payments shall be distributed to voluntary, non-profit diagnostic and treatment centers and to public diagnostic and treatment centers in accordance with paragraph (g) of subdivision four of this section. In the event that federal financial participation is available for rate adjustments pursuant to this section, the commissioner shall make such payments as additional adjustments to rates of payment for voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four-a of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, fifteen million dollars in the aggregate, and for the period January first, two thousand seven through June thirtieth, two thousand seven, seven million five hundred thousand dollars in the aggregate. The amounts allocated pursuant to this paragraph shall be aggregated with and distributed pursuant to the same methodology applicable to the amounts allocated to such diagnostic and treatment centers for such

periods pursuant to subdivision four of this section if federal financial participation is not available, or pursuant to subdivision four-a of this section if federal financial participation is available. Notwithstanding section three hundred sixty-eight-a of the social services law, there shall be no local share in a medical assistance payment adjustment under this subdivision.

§ 8. Subparagraph (xv) of paragraph (a) of subdivision 6 of section 2807-s of the public health law, as amended by section 11 of part Y of chapter 56 of the laws of 2020, is amended and a new subparagraph (xvi) is added to read as follows:

(xv) A gross annual statewide amount for the period January first, two thousand fifteen through December thirty-first, two thousand [~~twenty-three~~] twenty-two, shall be one billion forty-five million dollars.

(xvi) A gross annual statewide amount for the period January first, two thousand twenty-three to December thirty-first, two thousand twenty-six shall be one billion eighty-five million dollars, forty million dollars annually of which shall be allocated under section twenty-eight hundred seven-o of this article among the municipalities of and the state of New York based on each municipality's share and the state's share of early intervention program expenditures not reimbursable by the medical assistance program for the latest twelve month period for which such data is available.

§ 9. Paragraph (g) of subdivision 6 of section 2807-s of the public health law, as added by chapter 820 of the laws of 2021, is amended to read as follows:

(g) A further gross statewide amount for the state fiscal year two thousand twenty-two [~~and each state fiscal year thereafter~~] shall be forty million dollars.

§ 10. Subparagraph (xiii) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 12 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

(xiii) twenty-three million eight hundred thirty-six thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand [~~twenty-three~~] twenty-six;

§ 11. Subdivision 6 of section 2807-t of the public health law, as amended by section 13 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

6. Prospective adjustments. (a) The commissioner shall annually reconcile the sum of the actual payments made to the commissioner or the commissioner's designee for each region pursuant to section twenty-eight hundred seven-s of this article and pursuant to this section for the prior year with the regional allocation of the gross annual statewide amount specified in subdivision six of section twenty-eight hundred seven-s of this article for such prior year. The difference between the actual amount raised for a region and the regional allocation of the specified gross annual amount for such prior year shall be applied as a prospective adjustment to the regional allocation of the specified gross annual payment amount for such region for the year next following the calculation of the reconciliation. The authorized dollar value of the adjustments shall be the same as if calculated retrospectively.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, for covered lives assessment rate periods on and after January first, two thousand fifteen through December thirty-first, two thousand [~~twenty-three~~] twenty-one, for amounts collected in the aggregate in excess of one billion forty-five million dollars on an annual basis, **and for the period January first, two thousand twenty-two to December thir-**

ty-first, two thousand twenty-six for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis, prospective adjustments shall be suspended if the annual reconciliation calculation from the prior year would otherwise result in a decrease to the regional allocation of the specified gross annual payment amount for that region, provided, however, that such suspension shall be lifted upon a determination by the commissioner, in consultation with the director of the budget, that sixty-five million dollars in aggregate collections on an annual basis over and above one billion forty-five million dollars on an annual basis for the period on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-one and for the period January first, two thousand twenty-two to December thirty-first, two thousand twenty-six for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis have been reserved and set aside for deposit in the HCRA resources fund. Any amounts collected in the aggregate at or below one billion forty-five million dollars on an annual basis for the period on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-two, and for the period January first, two thousand twenty-three to December thirty-first, two thousand twenty-six for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis, shall be subject to regional adjustments reconciling any decreases or increases to the regional allocation in accordance with paragraph (a) of this subdivision.

§ 12. Section 2807-v of the public health law, as amended by section 14 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

§ 2807-v. Tobacco control and insurance initiatives pool distributions. 1. Funds accumulated in the tobacco control and insurance initiatives pool or in the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following:

(a) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of services and expenses related to the toll-free medicaid fraud hotline established pursuant to section one hundred eight of chapter one of the laws of nineteen hundred ninety-nine from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: four hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to four hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to four hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred thousand dollars for the period January first, two thousand

eight through December thirty-first, two thousand eight, up to four hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to four hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to one hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven and within amounts appropriated on and after April first, two thousand eleven.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of payment of audits or audit contracts necessary to determine payor and provider compliance with requirements set forth in sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five million six hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to seven million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and up to eight million three hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to eight million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fourteen million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**, and up to eleven million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six**.

(c) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, enhanced community services account, or any successor fund or account, for mental health services programs for case management services for adults and children; supported housing; home and community based waiver services; family based treatment; family support services; mobile mental health teams; transitional

housing; and community oversight, established pursuant to articles seven and forty-one of the mental hygiene law and subdivision nine of section three hundred sixty-six of the social services law; and for comprehensive care centers for eating disorders pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred from the enhanced community services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law; from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) forty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand, for the period January first, two thousand through December thirty-first, two thousand;

(ii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand one, for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand two, for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) eighty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand three, for the period January first, two thousand three through December thirty-first, two thousand three;

(v) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand four, and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand five, and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand six, and pursuant to former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) eighty-six million four hundred thousand dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand seven and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) twenty-two million nine hundred thirteen thousand dollars, plus one hundred twenty-five thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand eight and pursuant to the former section twenty-seven hundred ninety-

nine-l of this chapter, for the period January first, two thousand eight through March thirty-first, two thousand eight.

(d) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two, for administration and marketing costs associated with such program established pursuant to clause (A) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-seven million dollars for the period January first, two thousand one through December thirty-first, two thousand one; and

(iii) fifty-seven million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(e) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two for administration and marketing costs associated with such program established pursuant to clause (B) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) two million five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) thirty million five hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one; and

(iii) sixty-six million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(f) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of payment of administrative expenses of the department related to the family health plus program established pursuant to section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five hundred thousand dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand six, five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and five hundred thousand dollars for the period January first, two thousand eight through December thirty-first,

two thousand eight, five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven and within amounts appropriated on and after April first, two thousand eleven.

(g) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the health maintenance organization direct pay market program established pursuant to sections forty-three hundred twenty-one-a and forty-three hundred twenty-two-a of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-five million dollars for the period January first, two thousand through December thirty-first, two thousand of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(ii) up to thirty-six million dollars for the period January first, two thousand one through December thirty-first, two thousand one of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iii) up to thirty-nine million dollars for the period January first, two thousand two through December thirty-first, two thousand two of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iv) up to forty million dollars for the period January first, two thousand three through December thirty-first, two thousand three of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(v) up to forty million dollars for the period January first, two thousand four through December thirty-first, two thousand four of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vi) up to forty million dollars for the period January first, two thousand five through December thirty-first, two thousand five of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vii) up to forty million dollars for the period January first, two thousand six through December thirty-first, two thousand six of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty

percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(viii) up to forty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law; and

(ix) up to forty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight of which fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law.

(h) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York individual program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to six million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(ii) up to twenty-nine million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iii) up to five million one hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million six hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to thirty-four million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to fifty-four million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York group program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-four million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(ii) up to seventy-seven million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iii) up to ten million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million six hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to thirty-four million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to fifty-four million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

(i-1) Notwithstanding the provisions of paragraphs (h) and (i) of this subdivision, the commissioner shall reserve and accumulate up to two million five hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, one million four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, two million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, from funds otherwise available for distribution under such paragraphs for the services and expenses related to the pilot program for entertainment industry employees included in subsection (b) of section one thousand one hundred twenty-two of the insurance law, and an additional seven hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, an additional three hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven for services and expenses related to the pilot program for displaced workers included in subsection (c) of section one thousand one hundred twenty-two of the insurance law.

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the tobacco use prevention and control program established pursuant to sections thirteen hundred ninety-nine-ii and thirteen hundred ninety-nine-jj of this chapter, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to forty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to forty million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to thirty-six million nine hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to thirty-six million nine hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to forty million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to eighty-one million nine hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(viii) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(ix) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) up to eighty-seven million seven hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) up to twenty-one million four hundred twelve thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) up to fifty-two million one hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xiv) up to six million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xv) up to six million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xvi) up to six million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xvii) up to six million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(k) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, health care services account, or any successor fund or account, for purposes of services and expenses related to public health programs, including comprehensive care centers for eating disorders pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred from the health care services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law for periods prior to March thirty-first, two thousand eleven, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-one million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to forty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to eighty-one million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) one hundred twenty-two million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) one hundred eight million five hundred seventy-five thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) ninety-one million eight hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) one hundred fifty-six million six hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) one hundred fifty-one million four hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) twenty-nine million two hundred thirty-seven thousand two hundred fifty dollars, plus an additional one hundred twenty-five thousand dollars, for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) one hundred twenty million thirty-eight thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve; and

(xiv) one hundred nineteen million four hundred seven thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen.

(l) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the personal care and certified home health agency rate or fee increases established pursuant to subdivision three of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-three million two hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-three million two hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) twenty-three million two hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to sixty-five million two hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to sixty-five million two hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to sixty-five million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to sixty-five million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to sixty-five million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) up to sixteen million three hundred thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(m) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to home care workers insurance pilot demonstration programs established pursuant to subdivision two of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million eight hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) three million eight hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) three million eight hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to three million eight hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to three million eight hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to three million eight hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to three million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to three million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) up to nine hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(n) Funds shall be transferred by the commissioner and shall be deposited to the credit of the special revenue funds - other, miscellaneous special revenue fund - 339, elderly pharmaceutical insurance coverage program premium account authorized pursuant to the provisions of title three of article two of the elder law, or any successor fund or account, for funding state expenses relating to the program from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) one hundred seven million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) one hundred sixty-four million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) three hundred twenty-two million seven hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) four hundred thirty-three million three hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) five hundred four million one hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) five hundred sixty-six million eight hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) six hundred three million one hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) six hundred sixty million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) three hundred sixty-seven million four hundred sixty-three thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) three hundred thirty-four million eight hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) three hundred forty-four million nine hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) eighty-seven million seven hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) one hundred forty-three million one hundred fifty thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(xiv) one hundred twenty million nine hundred fifty thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen;

(xv) one hundred twenty-eight million eight hundred fifty thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen;

(xvi) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xvii) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xviii) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xix) one hundred twenty-seven million four hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(o) Funds shall be reserved and accumulated and shall be transferred to the Roswell Park Cancer Institute Corporation, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to ninety million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to sixty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to eighty-five million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) eighty-five million two hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) seventy-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) seventy-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) ninety-one million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) seventy-eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) seventy-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) seventy-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) seventy-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) nineteen million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) sixty-nine million eight hundred forty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xiv) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xv) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xvi) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xvii) up to ninety-six million six hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(p) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, indigent care fund - 068, indigent care account, or any successor fund or account, for purposes of providing a medicaid disproportionate share payment from the high need indigent care adjustment pool established pursuant to section twenty-eight hundred seven-w of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighty-two million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two;

(ii) up to eighty-two million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to eighty-two million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to eighty-two million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eighty-two million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to eighty-two million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to eighty-two million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to eighty-two million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to eighty-two million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to twenty million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) up to eighty-two million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(q) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing distributions to eligible school based health centers established pursuant to section eighty-eight of chapter one of the laws of nineteen hundred ninety-nine, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) seven million dollars annually for the period January first, two thousand through December thirty-first, two thousand two;

(ii) up to seven million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to seven million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to seven million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to seven million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to seven million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;
(vii) up to seven million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;
(viii) up to seven million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;
(ix) up to seven million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;
(x) up to one million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;
(xi) up to five million six hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;
(xii) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;
(xiii) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]
(xiv) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three; and
(xv) up to five million two hundred eighty-eight thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.
(r) Funds shall be deposited by the commissioner within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of providing distributions for supplementary medical insurance for Medicare part B premiums, physicians services, outpatient services, medical equipment, supplies and other health services, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:
(i) forty-three million dollars for the period January first, two thousand through December thirty-first, two thousand;
(ii) sixty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;
(iii) sixty-five million dollars for the period January first, two thousand two through December thirty-first, two thousand two;
(iv) sixty-seven million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;
(v) sixty-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;
(vi) sixty-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;
(vii) sixty-eight million dollars for the period January first, two thousand six through December thirty-first, two thousand six;
(viii) seventeen million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;
(ix) sixty-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) sixty-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) sixty-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) seventeen million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xiii) sixty-eight million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(s) Funds shall be deposited by the commissioner within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of providing distributions pursuant to paragraphs (s-5), (s-6), (s-7) and (s-8) of subdivision eleven of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighteen million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-four million dollars annually for the periods January first, two thousand one through December thirty-first, two thousand two;

(iii) up to twenty-four million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to twenty-four million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to twenty-four million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to twenty-four million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(viii) up to twenty-four million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(ix) up to twenty-two million dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(t) Funds shall be reserved and accumulated from year to year by the commissioner and shall be made available, including income from invested funds:

(i) For the purpose of making grants to a state owned and operated medical school which does not have a state owned and operated hospital on site and available for teaching purposes. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, such grants shall be made in the amount of up to five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) For the purpose of making grants to medical schools pursuant to section eighty-six-a of chapter one of the laws of nineteen hundred ninety-nine in the sum of up to four million dollars for the period January first, two thousand through December thirty-first, two thousand; and

(iii) The funds disbursed pursuant to subparagraphs (i) and (ii) of this paragraph from the tobacco control and insurance initiatives pool are contingent upon meeting all funding amounts established pursuant to paragraphs (a), (b), (c), (d), (e), (f), (l), (m), (n), (p), (q), (r)

and (s) of this subdivision, paragraph (a) of subdivision nine of section twenty-eight hundred seven-j of this article, and paragraphs (a), (i) and (k) of subdivision one of section twenty-eight hundred seven-l of this article.

(u) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to the nursing home quality improvement demonstration program established pursuant to section twenty-eight hundred eight-d of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to twenty-five million dollars for the period beginning April first, two thousand two and ending December thirty-first, two thousand two, and on an annualized basis, for each annual period thereafter beginning January first, two thousand three and ending December thirty-first, two thousand four;

(ii) up to eighteen million seven hundred fifty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

(iii) up to fifty-six million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(v) Funds shall be transferred by the commissioner and shall be deposited to the credit of the hospital excess liability pool created pursuant to section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, or any successor fund or account, for purposes of expenses related to the purchase of excess medical malpractice insurance and the cost of administrating the pool, including costs associated with the risk management program established pursuant to section forty-two of part A of chapter one of the laws of two thousand two required by paragraph (a) of subdivision one of section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as may be amended from time to time, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to fifty million dollars or so much as is needed for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to seventy-six million seven hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to sixty-five million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to sixty-five million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to one hundred thirteen million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to one hundred thirty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to one hundred thirty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to one hundred thirty million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to one hundred thirty million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to thirty-two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xiv) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xv) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(w) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the treatment of breast and cervical cancer pursuant to paragraph (d) of subdivision four of section three hundred sixty-six of the social services law, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to four hundred fifty thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to two million one hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to two million one hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to two million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to two million one hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to two million one hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to two million one hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to two million one hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million one hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to five hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xiv) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xv) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(x) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the non-public general hospital rates increases for recruitment and retention of health care workers from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-seven million one hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) fifty million eight hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) sixty-nine million three hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) sixty-nine million three hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) sixty-nine million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) sixty-five million three hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) sixty-one million one hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) forty-eight million seven hundred twenty-one thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(y) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to public general hospitals for recruitment and retention of health care workers pursuant to paragraph (b) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighteen million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) thirty-seven million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) fifty-two million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) fifty-two million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) fifty-two million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) forty-nine million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) forty-nine million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) twelve million two hundred fifty thousand dollars for the period January first, two thousand nine through March thirty-first, two thousand nine.

Provided, however, amounts pursuant to this paragraph may be reduced in an amount to be approved by the director of the budget to reflect amounts received from the federal government under the state's 1115 waiver which are directed under its terms and conditions to the health workforce recruitment and retention program.

(z) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the non-public residential health care facility rate increases for recruitment and retention of health care workers pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-one million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) thirty-three million three hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) forty-six million three hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) forty-six million three hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) forty-six million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) thirty million nine hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) twenty-four million seven hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) twelve million three hundred seventy-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) nine million three hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) two million three hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(aa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to public residential health care facilities for recruitment and retention of health care workers pursuant to paragraph (b) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) seven million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) eleven million seven hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) sixteen million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) sixteen million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) sixteen million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) ten million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) six million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) one million three hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine.

(bb)(i) Funds shall be deposited by the commissioner, within amounts appropriated, and subject to the availability of federal financial participation, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special

revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which include a city with a population of over one million persons and computed and distributed in accordance with memorandums of understanding to be entered into between the state of New York and such local social service districts for the purpose of supporting the recruitment and retention of personal care service workers or any worker with direct patient care responsibility, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

(A) forty-four million dollars, on an annualized basis, for the period April first, two thousand two through December thirty-first, two thousand two;

(B) seventy-four million dollars, on an annualized basis, for the period January first, two thousand three through December thirty-first, two thousand three;

(C) one hundred four million dollars, on an annualized basis, for the period January first, two thousand four through December thirty-first, two thousand four;

(D) one hundred thirty-six million dollars, on an annualized basis, for the period January first, two thousand five through December thirty-first, two thousand five;

(E) one hundred thirty-six million dollars, on an annualized basis, for the period January first, two thousand six through December thirty-first, two thousand six;

(F) one hundred thirty-six million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(G) one hundred thirty-six million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(H) one hundred thirty-six million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(I) one hundred thirty-six million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(J) thirty-four million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(K) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(L) up to one hundred thirty-six million dollars each state fiscal year for the period March thirty-first, two thousand fourteen through April first, two thousand seventeen;

(M) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(N) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(O) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(ii) Adjustments to Medicaid rates made pursuant to this paragraph shall not, in aggregate, exceed the following amounts for the following periods:

(A) for the period April first, two thousand two through December thirty-first, two thousand two, one hundred ten million dollars;

(B) for the period January first, two thousand three through December thirty-first, two thousand three, one hundred eighty-five million dollars;

(C) for the period January first, two thousand four through December thirty-first, two thousand four, two hundred sixty million dollars;

(D) for the period January first, two thousand five through December thirty-first, two thousand five, three hundred forty million dollars;

(E) for the period January first, two thousand six through December thirty-first, two thousand six, three hundred forty million dollars;

(F) for the period January first, two thousand seven through December thirty-first, two thousand seven, three hundred forty million dollars;

(G) for the period January first, two thousand eight through December thirty-first, two thousand eight, three hundred forty million dollars;

(H) for the period January first, two thousand nine through December thirty-first, two thousand nine, three hundred forty million dollars;

(I) for the period January first, two thousand ten through December thirty-first, two thousand ten, three hundred forty million dollars;

(J) for the period January first, two thousand eleven through March thirty-first, two thousand eleven, eighty-five million dollars;

(K) for each state fiscal year within the period April first, two thousand eleven through March thirty-first, two thousand fourteen, three hundred forty million dollars;

(L) for each state fiscal year within the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, three hundred forty million dollars;

(M) for each state fiscal year within the period April first, two thousand seventeen through March thirty-first, two thousand twenty, three hundred forty million dollars; [~~and~~]

(N) for each state fiscal year within the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, three hundred forty million dollars**; and**

(O) for each state fiscal year within the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, three hundred forty million dollars.

(iii) Personal care service providers which have their rates adjusted pursuant to this paragraph shall use such funds for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility only and are prohibited from using such funds for any other purpose. Each such personal care services provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such provider to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(cc) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which shall not include a city with a population of over one million persons for the purpose of supporting the personal care services worker recruitment and retention program as established pursuant to section three hundred sixty-seven-q of the social services law, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

(i) two million eight hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) five million six hundred thousand dollars, on an annualized basis, for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eight million four hundred thousand dollars, on an annualized basis, for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) ten million eight hundred thousand dollars, on an annualized basis, for the period January first, two thousand five through December thirty-first, two thousand five;

(v) ten million eight hundred thousand dollars, on an annualized basis, for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eleven million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eleven million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eleven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eleven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) two million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xiv) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xv) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(dd) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures for physician services from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to fifty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) eighty-one million two hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eighty-five million two hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) eighty-five million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) eighty-five million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eighty-five million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eighty-five million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eighty-five million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eighty-five million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) twenty-one million three hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) eighty-five million two hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(ee) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the free-standing diagnostic and treatment center rate increases for recruitment and retention of health care workers pursuant to subdivision seventeen of section twenty-eight hundred seven of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million two hundred fifty thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) three million two hundred fifty thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) three million two hundred fifty thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) three million two hundred fifty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) three million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) three million two hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) three million four hundred thirty-eight thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) two million four hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) one million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) three hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(ff) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures for disabled persons as authorized pursuant to former subparagraphs twelve and thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) one million eight hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) sixteen million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eighteen million seven hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) thirty million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) thirty million six hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) thirty million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) fifteen million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) fifteen million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) fifteen million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) fifteen million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) fifteen million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xiv) fifteen million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xv) fifteen million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(gg) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (c) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to one million three hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to three million two hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to five million six hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to eight million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eight million six hundred thousand dollars on an annualized basis for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to two million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to two million six hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to two million six hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) up to six hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(hh) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue fund - other, HCRA transfer fund, medical assistance account for purposes of providing financial assistance to residential health care facilities pursuant to subdivisions nineteen and twenty-one of section twenty-eight hundred eight of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) for the period April first, two thousand two through December thirty-first, two thousand two, ten million dollars;

(ii) for the period January first, two thousand three through December thirty-first, two thousand three, nine million four hundred fifty thousand dollars;

(iii) for the period January first, two thousand four through December thirty-first, two thousand four, nine million three hundred fifty thousand dollars;

(iv) up to fifteen million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to fifteen million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to fifteen million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to fifteen million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to fifteen million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) fifteen million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(ii) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for disabled persons as authorized by sections 1619 (a) and (b) of the federal social security act pursuant to the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) six million four hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) eight million five hundred thousand dollars, for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eight million five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) eight million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) eight million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eight million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eight million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eight million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xi) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(xii) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(xiii) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(xiv) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xv) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(jj) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purposes of a grant program to improve access to infertility services, treatments and procedures, from the tobacco control and insurance initiatives pool established for the period January first, two thousand two through December thirty-first, two thousand two in the amount of nine million one hundred seventy-five thousand dollars, for the period April first, two thousand six through March thirty-first, two thousand seven in the amount of five million dollars, for the period April first, two thousand seven through March thirty-first, two thousand eight in the amount of five million dollars, for the period April first, two thousand eight through March thirty-first, two thousand nine in the amount of five million dollars, and for the period April first, two thousand nine through March thirty-first, two thousand ten in the amount of five million dollars, for the period April first, two thousand ten through March thirty-first, two thousand eleven in the amount of two million two hundred thousand dollars, and for the period April first, two thousand eleven through March thirty-first, two thousand twelve up to one million one hundred thousand dollars.

(kk) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and

directed to receive for deposit to the credit of the state special revenue funds -- other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medical Assistance Program expenditures from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) thirty-eight million eight hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to two hundred ninety-five million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to four hundred seventy-two million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to nine hundred million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eight hundred sixty-six million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to six hundred sixteen million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to five hundred seventy-eight million nine hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) within amounts appropriated on and after January first, two thousand nine.

(ll) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds -- other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures related to the city of New York from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighty-two million seven hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) one hundred twenty-four million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) thirty-one million one hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) one hundred twenty-four million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(mm) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding specified percentages of the state share of services and expenses related to the family health plus program in accordance with the following schedule:

(i) (A) for the period January first, two thousand three through December thirty-first, two thousand four, one hundred percent of the state share;

(B) for the period January first, two thousand five through December thirty-first, two thousand five, seventy-five percent of the state share; and

(C) for periods beginning on and after January first, two thousand six, fifty percent of the state share.

(ii) Funding for the family health plus program will include up to five million dollars annually for the period January first, two thousand three through December thirty-first, two thousand six, up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to seven million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to seven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to seven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to one million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to six million forty-nine thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to six million two hundred eighty-nine thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, and up to six million four hundred sixty-one thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, for administration and marketing costs associated with such program established pursuant to clauses (A) and (B) of subparagraph (v) of paragraph (a) of subdivision two of **the former** section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(A) one hundred ninety million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(B) three hundred seventy-four million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(C) five hundred thirty-eight million four hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(D) three hundred eighteen million seven hundred seventy-five thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(E) four hundred eighty-two million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(F) five hundred seventy million twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(G) six hundred ten million seven hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(H) six hundred twenty-seven million two hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(I) one hundred fifty-seven million eight hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(J) six hundred twenty-eight million four hundred thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(K) six hundred fifty million four hundred thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen;

(L) six hundred fifty million four hundred thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen; and

(M) up to three hundred ten million five hundred ninety-five thousand dollars for the period April first, two thousand fourteen through March thirty-first, two thousand fifteen.

(nn) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, health care services account, or any successor fund or account, for purposes related to adult home initiatives for medicaid eligible residents of residential facilities licensed pursuant to section four hundred sixty-b of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to four million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(ii) up to six million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iii) up to eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited

to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(iv) up to eight million dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(v) up to eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(vi) up to two million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(vii) up to two million seven hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(viii) up to two million seven hundred fifty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(ix) up to six hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(oo) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (e) of subdivision twenty-five of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to five million dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iv) up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(v) up to five million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(vi) up to five million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(vii) up to five million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(viii) up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(pp) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the provision of tax credits for long term care insurance pursuant to subdivision one of section one hundred ninety of the tax law, paragraph (a) of subdivision fourteen of section two hundred ten-B of such law, subsection (aa) of section six hundred six of such law and paragraph one of subdivision (m) of section fifteen hundred eleven of such law, in the following amounts:

(i) ten million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) ten million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) ten million dollars for the period January first, two thousand six through December thirty-first, two thousand six; and

(iv) five million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven.

(qq) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the long-term care insurance education and outreach program established pursuant to section two hundred seventeen-a of the elder law for the following periods in the following amounts:

(i) up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(ii) up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(iii) up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term

care insurance resource centers with the necessary resources to carry out their operations;

(iv) up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(v) up to five million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(vi) up to five million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long-term care insurance resource centers with the necessary resources to carry out their operations;

(vii) up to four hundred eighty-eight thousand dollars for the period January first, two thousand ten through March thirty-first, two thousand ten; of such funds four hundred eighty-eight thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program.

(rr) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and shall be available, including income from invested funds, for the purpose of supporting expenses related to implementation of the provisions of title three of article twenty-nine-D of this chapter, for the following periods and in the following amounts:

(i) up to ten million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(ii) up to ten million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iii) up to ten million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(iv) up to ten million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(v) up to ten million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(vi) up to two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(ss) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and used for a health care stabilization program established by the commissioner for the purposes of stabilizing

critical health care providers and health care programs whose ability to continue to provide appropriate services are threatened by financial or other challenges, in the amount of up to twenty-eight million dollars for the period July first, two thousand four through June thirtieth, two thousand five. Notwithstanding the provisions of section one hundred twelve of the state finance law or any other inconsistent provision of the state finance law or any other law, funds available for distribution pursuant to this paragraph may be allocated and distributed by the commissioner, or the state comptroller as applicable without a competitive bid or request for proposal process. Considerations relied upon by the commissioner in determining the allocation and distribution of these funds shall include, but not be limited to, the following: (i) the importance of the provider or program in meeting critical health care needs in the community in which it operates; (ii) the provider or program provision of care to under-served populations; (iii) the quality of the care or services the provider or program delivers; (iv) the ability of the provider or program to continue to deliver an appropriate level of care or services if additional funding is made available; (v) the ability of the provider or program to access, in a timely manner, alternative sources of funding, including other sources of government funding; (vi) the ability of other providers or programs in the community to meet the community health care needs; (vii) whether the provider or program has an appropriate plan to improve its financial condition; and (viii) whether additional funding would permit the provider or program to consolidate, relocate, or close programs or services where such actions would result in greater stability and efficiency in the delivery of needed health care services or programs.

(tt) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing grants for two long term care demonstration projects designed to test new models for the delivery of long term care services established pursuant to section twenty-eight hundred seven-x of this chapter, for the following periods and in the following amounts:

(i) up to five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) up to five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) up to five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iv) up to one million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(v) up to two hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(uu) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting disease management and telemedicine demonstration programs authorized pursuant to section twenty-one hundred eleven of this chapter for the following periods in the following amounts:

(i) five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, of which three million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(ii) five million dollars for the period January first, two thousand five through December thirty-first, two thousand five, of which three

million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(iii) nine million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(iv) nine million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and one million dollars shall be available for telemedicine demonstration programs;

(v) nine million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(vi) seven million eight hundred thirty-three thousand three hundred thirty-three dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and three hundred thirty-three thousand three hundred thirty-three dollars shall be available for telemedicine demonstration programs for the period January first, two thousand nine through March first, two thousand nine;

(vii) one million eight hundred seventy-five thousand dollars for the period January first, two thousand ten through March thirty-first, two thousand ten shall be available for disease management demonstration programs.

(ww) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the general hospital rates increases for recruitment and retention of health care workers pursuant to paragraph (e) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) sixty million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

(ii) sixty million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(xx) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the general hospital rates increases for rural hospitals pursuant to subdivision thirty-two of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(ii) three million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iii) three million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iv) three million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(v) three million two hundred eight thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(yy) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated and notwithstanding section one hundred twelve of the state finance law and any other contrary provision of law, for the purpose of supporting grants not to exceed five million dollars to be made by the commissioner without a competitive bid or request for proposal process, in support of the delivery of critically needed health care services, to health care providers located in the counties of Erie and Niagara which executed a memorandum of closing and conducted a merger closing in escrow on November twenty-fourth, nineteen hundred ninety-seven and which entered into a settlement dated December thirtieth, two thousand four for a loss on disposal of assets under the provisions of title XVIII of the federal social security act applicable to mergers occurring prior to December first, nineteen hundred ninety-seven.

(zz) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated, for the purpose of supporting expenditures authorized pursuant to section twenty-eight hundred eighteen of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) six million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(ii) one hundred eight million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated in the two thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

(iii) one hundred seventy-one million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated in the two thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

(iv) one hundred seventy-one million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(v) one hundred twenty-eight million seven hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(vi) one hundred thirty-one million three hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(vii) thirty-four million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(viii) four hundred thirty-three million three hundred sixty-six thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(ix) one hundred fifty million eight hundred six thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen;

(x) seventy-eight million seventy-one thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen.

(aaa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for services and expenses related to school based health centers, in an amount up to three million five hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million five hundred thousand dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, up to three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, up to three million five hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, up to three million five hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to two million eight hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, [~~and~~] up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**, and up to two million six hundred forty-four thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six**. The total amount of funds provided herein shall be distributed as grants based on the ratio of each provider's total enrollment for all sites to the total enrollment of all providers. This formula shall be applied to the total amount provided herein.

(bbb) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of awarding grants to operators of adult homes, enriched housing programs and residences through the enhancing abilities and life experience (EnAbLe) program to provide for the installation, operation and maintenance of air conditioning in resident rooms, consistent with this paragraph, in an amount up to two million dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million eight hundred thousand dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, up to three million eight hundred thousand dollars for the period

April first, two thousand eight through March thirty-first, two thousand nine, up to three million eight hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, and up to three million eight hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven. Residents shall not be charged utility cost for the use of air conditioners supplied under the EnAbLe program. All such air conditioners must be operated in occupied resident rooms consistent with requirements applicable to common areas.

(ccc) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of increases in the rates for certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs and managed long term care plans and approved managed long term care operating demonstrations as defined in section forty-four hundred three-f of this chapter for recruitment and retention of health care workers pursuant to subdivisions nine and ten of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-five million dollars for the period June first, two thousand six through December thirty-first, two thousand six;

(ii) fifty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iii) fifty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(iv) fifty million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(v) fifty million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(vi) twelve million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(vii) up to fifty million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(viii) up to fifty million dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen;

(ix) up to fifty million dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty; [~~and~~]

(x) up to fifty million dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three**; and**

(xi) up to fifty million dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six.

(ddd) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state

share of increases in the medical assistance rates for providers for purposes of enhancing the provision, quality and/or efficiency of home care services pursuant to subdivision eleven of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following period in the amount of eight million dollars for the period April first, two thousand six through December thirty-first, two thousand six.

(eee) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, to the Center for Functional Genomics at the State University of New York at Albany, for the purposes of the Adirondack network for cancer education and research in rural communities grant program to improve access to health care and shall be made available from the tobacco control and insurance initiatives pool established for the following period in the amount of up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(fff) Funds shall be made available to the empire state stem cell trust fund established by section ninety-nine-p of the state finance law within amounts appropriated up to fifty million dollars annually and shall not exceed five hundred million dollars in total.

(ggg) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for hospital translation services as authorized pursuant to paragraph (k) of subdivision one of section twenty-eight hundred seven-c of this article from the tobacco control and initiatives pool established for the following periods in the following amounts:

(i) sixteen million dollars for the period July first, two thousand eight through December thirty-first, two thousand eight; and

(ii) fourteen million seven hundred thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(hhh) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for adjustments to inpatient rates of payment for general hospitals located in the counties of Nassau and Suffolk as authorized pursuant to paragraph (l) of subdivision one of section twenty-eight hundred seven-c of this article from the tobacco control and initiatives pool established for the following periods in the following amounts:

(i) two million five hundred thousand dollars for the period April first, two thousand eight through December thirty-first, two thousand eight; and

(ii) two million two hundred ninety-two thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(iii) Funds shall be reserved and set aside and accumulated from year to year and shall be made available, including income from investment funds, for the purpose of supporting the New York state medical indemnity fund as authorized pursuant to title four of article twenty-nine-D

of this chapter, for the following periods and in the following amounts, provided, however, that the commissioner is authorized to seek waiver authority from the federal centers for medicare and Medicaid for the purpose of securing Medicaid federal financial participation for such program, in which case the funding authorized pursuant to this paragraph shall be utilized as the non-federal share for such payments:

Thirty million dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve.

2. (a) For periods prior to January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or such other contractors as the commissioner shall designate, to receive and distribute funds from the tobacco control and insurance initiatives pool established pursuant to this section. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of such funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis five hundred thousand dollars, for collection and distribution of funds pursuant to this section shall be paid from such funds.

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process, contracts in effect for administration of pools established pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-l and twenty-eight hundred seven-m of this article for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine may be extended to provide for administration pursuant to this section and may be amended as may be necessary.

§ 13. Paragraph (a) of subdivision 12 of section 367-b of the social services law, as amended by section 15 of part Y of chapter 56 of the laws of 2020, is amended to read as follows:

(a) For the purpose of regulating cash flow for general hospitals, the department shall develop and implement a payment methodology to provide for timely payments for inpatient hospital services eligible for case based payments per discharge based on diagnosis-related groups provided during the period January first, nineteen hundred eighty-eight through March thirty-first two thousand [~~twenty-three~~] twenty-six, by such hospitals which elect to participate in the system.

§ 14. Paragraph (r) of subdivision 9 of section 3614 of the public health law, as added by section 16 of part Y of chapter 56 of the laws of 2020, is amended and three new paragraphs (s), (t) and (u) are added to read as follows:

(r) for the period April first, two thousand twenty-two through March thirty-first, two thousand twenty-three, up to one hundred million dollars[~~.~~];

(s) for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-four, up to one hundred million dollars;

(t) for the period April first, two thousand twenty-four through March thirty-first, two thousand twenty-five, up to one hundred million dollars;

(u) for the period April first, two thousand twenty-five through March thirty-first, two thousand twenty-six, up to one hundred million dollars.

§ 15. Paragraph (v) of subdivision 1 of section 367-q of the social services law, as added by section 17 of part Y of chapter 56 of the laws of 2020, is amended and three new paragraphs (w), (x) and (y) are added to read as follows:

(v) for the period April first, two thousand twenty-two through March thirty-first, two thousand twenty-three, up to twenty-eight million five hundred thousand dollars[~~.~~]~~;~~

(w) for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-four, up to twenty-eight million five hundred thousand dollars;

(x) for the period April first, two thousand twenty-four through March thirty-first, two thousand twenty-five, up to twenty-eight million five hundred thousand dollars;

(y) for the period April first, two thousand twenty-five through March thirty-first, two thousand twenty-six, up to twenty-eight million five hundred thousand dollars.

§ 16. This act shall take effect April 1, 2023; provided, however, if this act shall become a law after such date it shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023; and further provided, that:

(a) the amendments to sections 2807-j and 2807-s of the public health law made by sections two, eight, nine, and ten of this act shall not affect the expiration of such sections and shall expire therewith;

(b) the amendments to subdivision 6 of section 2807-t of the public health law made by section eleven of this act shall not affect the expiration of such section and shall be deemed to expire therewith; and

(c) the amendments to paragraph (i-1) of subdivision 1 of section 2807-v of the public health law made by section twelve of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith.

PART D

Intentionally Omitted

PART E

Section 1. Subdivision 5-d of section 2807-k of the public health law, as amended by section 3 of part KK of chapter 56 of the laws of 2020, is amended to read as follows:

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand twenty, through March thirty-first, two thousand [~~twenty-three~~] **twenty-six**, all funds available for distribution pursuant to this section, except for funds distributed pursuant to [~~subparagraph (v) of~~] paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand twenty through two thousand [~~twenty-two~~] twenty-five calendar years shall be in accord with the following:

(A) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals; and

(B) nine hundred sixty-nine million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

For the calendar years two thousand twenty through two thousand twenty-two, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of one hundred fifty million dollars annually, provided that eligible general hospitals, other than major public general hospitals, that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article shall not be subject to such reduction.

For the calendar years two thousand twenty-three through two thousand twenty-five, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of two hundred thirty-five million four hundred thousand dollars annually, provided that eligible general hospitals, other than major public general hospitals that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty, shall not be subject to such reduction.

Such [~~reduction~~] reductions shall be determined by a methodology to be established by the commissioner. Such [~~methodology~~] methodologies may take into account the payor mix of each non-public general hospital, including the percentage of inpatient days paid by Medicaid.

(iii) For calendar years two thousand twenty through two thousand [~~twenty-two~~] twenty-five, sixty-four million six hundred thousand dollars shall be distributed to eligible general hospitals, other than major public general hospitals, that experience a reduction in indigent care pool payments pursuant to this subdivision, and that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty. Such distribution shall be established pursuant to regulations promulgated by the commissioner and shall be proportional to the reduction experienced by the facility.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, and for calendar years thereafter, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen

hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

§ 2. Subdivision 1 of section 2801 of the public health law, as amended by section 1 of part Z of chapter 57 of the laws of 2019, is amended to read as follows:

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, **a rural emergency hospital under 42 USC 1395x(kkk), or successor provisions,** dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. No provision of this article or any other provision of law shall be construed to: (a) limit the volume of mental health, substance use disorder services or developmental disability services that can be provided by a provider of primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve; (b) require a provider licensed pursuant to article thirty-one of the mental hygiene law or certified pursuant to article sixteen or article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regu-

lations issued by the commissioner in consultation with the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

§ 3. Section 2801-g of the public health law is amended by adding a new subdivision 4 to read as follows:

4. At least thirty days prior to a general hospital applying to the federal centers for medicare and medicaid services to convert from a general hospital with inpatients to a rural emergency hospital under 42 USC 1395x(kkk), or successor provisions, such hospital shall hold a public community forum for the purpose of obtaining public input concerning the anticipated impact of the hospital's closure of inpatient units, including but not limited to, the impact on recipients of medical assistance for needy persons, the uninsured, and medically underserved populations, and options and proposals to ameliorate such anticipated impact. The hospital shall afford all public participants a reasonable opportunity to speak about relevant matters at such community forum. Prior to any community forum and as soon as practicable, the hospital shall be required to:

(a) notify the office of mental health and the local director of community services in the event such general hospital has psychiatric inpatient beds licensed under article thirty-one of the mental hygiene law or designated pursuant to section 9.39 of the mental hygiene law, and

(b) notify the office of addiction services and supports in the event such general hospital has inpatient substance use disorder treatment programs or inpatient chemical dependence treatment programs licensed under article thirty-two of the mental hygiene law.

§ 4. The opening paragraph of subdivision (g) of section 2826 of the public health law, as amended by section 3 of part M of chapter 57 of the laws of 2022, is 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 twenty-two through March thirty-first, two thousand 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 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 application, and** 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, **application, and** evaluation process [~~**and guidance for transformation plans**~~] and notification of any award recipients.

§ 5. Subparagraph (F) of paragraph (i) of subdivision (g) of section 2826 of the public health law, as amended by section 3 of part M of chapter 57 of the laws of 2022, is amended to read as follows:

(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; or an entity that was formed as a preferred provider system pursuant to the delivery system reform incentive payment (DSRIP) program and collaborated with an independent practice association that received VBP innovator status from the department for purposes of meeting DSRIP goals, and which preferred provider system remains operational as an integrated care system.

§ 6. The opening paragraph of paragraph (ii) 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, is amended to read as follows:

Eligible applicants must demonstrate that without such award, they will be in severe financial distress [~~through March thirty-first, two thousand sixteen~~], as evidenced by:

§ 7. Subparagraph (A), the opening paragraph of subparagraph (E) and subparagraph (F) of paragraph (iii) 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:

(A) [~~Applications under this subdivision~~] Eligible applicants shall [~~include a multi-year transformation plan that is aligned with the delivery system reform incentive payment ("DSRIP") program goals and objectives. Such plan shall be approved by~~] submit a completed application to the department [~~and shall demonstrate a path towards long-term sustainability and improved patient care~~].

The department shall review all applications under this subdivision, and [~~a~~] determine:

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department [~~shall~~] may make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

§ 8. Paragraph (v) 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, is amended to read as follows:

(v) Payments made to awardees pursuant to this subdivision [~~shall be~~] that are made on a monthly basis[~~. Such payments~~] will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

§ 9. Part I of chapter 57 of the laws of 2022 relating to providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, is amended by adding a new section 1-a to read as follows:

§ 1-a. Notwithstanding any provision of law to the contrary, subject to appropriations, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of hospital inpatient and outpatient services shall be subject to a uniform rate increase of ten percent in addition to the increase contained in section one of this act, subject to the approval of the commissioner of health and the director of the budget. Such rate increase shall be subject to federal financial participation.

§ 10. This act shall take effect immediately; provided that sections two and three of this act shall take effect on the sixtieth day after it shall have become a law; provided, further, that sections one, four,

five, six, seven, eight, and nine of this act shall be deemed to have been in full force and effect on and after April 1, 2023.

PART F

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 Z of chapter 57 of the laws of 2022, 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, between July 1, 2021 and June 30, 2022, [~~and~~] between July 1, 2022 and June 30, 2023**, and between July 1, 2023 and June 30, 2024** 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, between July 1, 2021 and June 30, 2022, [~~and~~] between July 1, 2022 and June 30, 2023**, and between July 1, 2023 and June 30, 2024** 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 Z of chapter 57 of the laws of 2022, 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, between July 1, 2021 and June 30, 2022, [~~and~~] between July 1, 2022 and June 30, 2023**, and between July 1, 2023 and June 30, 2024** allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, [~~and~~] between July 1, 2022 and June 30, 2023**, and between July 1, 2023 and June 30, 2024** allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent

excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, to the period July 1, 2016 and June 30, 2017, to the period July 1, 2017 to June 30, 2018, to the period July 1, 2018 to June 30, 2019, to the period July 1, 2019 to June 30, 2020, to the period July 1, 2020 to June 30, 2021, to the period July 1, 2021 to June 30, 2022, [~~and~~] to the period July 1, 2022 to June 30, 2023**, and to the period July 1, 2023 to June 30, 2024**.

§ 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 Z of chapter 57 of the laws of 2022, 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, during the period July 1, 2021 to June 30, 2022, [~~and~~] during the period July 1, 2022 to June 30, 2023**, and during the period July 1, 2023 to June 30, 2024** 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**, or covering the period July 1, 2023 to June 30, 2024** 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**, or covering the period July 1, 2023 to June 30, 2024** 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~~] **30**, 2023**, or covering the period July 1, 2023 to June 30, 2024** 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**, and to the period July 1, 2023 to June 30, 2024** 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**, and covering the period July 1, 2023 to June 30, 2024** 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 Z of chapter 57 of the laws of 2022, 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, [~~2023~~] **2024**; 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, [~~2023~~] **2024**, 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, [~~2023~~] **2024** 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 Z of chapter 57 of the laws of 2022, 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, June 15, 2022, [~~and~~] June 15, 2023**, and June 15, 2024** 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**, or July 1, 2023 to June 30, 2024** 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**, or July 1, 2023 to June 30, 2024** 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, June 15, 2022, [~~and~~] June 15, 2023**, and June 15, 2024** 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 Z of chapter 57 of the laws of 2022, 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-two~~] **twenty-three**, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [~~twenty-two~~] **twenty-three**; 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-two~~] **twenty-three** exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [~~twenty-two~~] **twenty-**

three, 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-two~~] twenty-three, 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-two~~] twenty-three 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-two~~] twenty-three.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023.

PART G

Section 1. Paragraph (a) of subdivision 12 of section 203 of the elder law, as added by section 1 of part U of chapter 57 of the laws of 2019, is amended to read as follows:

(a) The director is hereby authorized to implement private pay protocols for programs and services administered by the office. These protocols may be implemented by area agencies on aging at their option and such protocols shall not be applied to services for a participant when being paid for with federal funds or funds designated as federal match, or for individuals with an income below [~~four~~] two hundred and fifty percent of the federal poverty level. All private payments received directly by an area agency on aging or indirectly by one of its contractors shall be used to supplement, not supplant, funds by state, federal, or county appropriations. Such private pay payments shall be set at a cost to the participant of not more than twenty percent above either the unit cost to the area agency on aging to provide the program or service directly, or the amount that the area agency on aging pays to its contractor to provide the program or service. Private pay payments received under this subdivision shall be used by the area agency on aging to first reduce any unmet need for programs and services, and then to support and enhance services or programs provided by the area agency on aging. No participant, regardless of income, shall be required to pay for any program or service that they are receiving at the time these protocols are implemented by the area agency on aging. This subdivision shall not prevent cost sharing for the programs and services established pursuant to section two hundred fourteen of this title [~~for individuals below four hundred percent of the federal poverty level~~]. Consistent with federal and state statute and regulations, when providing programs and services, area agencies on aging and their contractors shall continue to give priority for programs and services to individuals with the greatest economic or social needs. In the event that the capacity to provide programs and services is limited, such programs and services shall be provided to individuals with incomes below [~~four~~] two hundred and fifty percent of the federal poverty level before such programs and services are provided to those participating in the private pay protocol pursuant to this subdivision.

§ 2. This act shall take effect immediately.

PART H

Section 1. Intentionally omitted.

§ 2. Short title. This act shall be known and may be cited as the "1332 state innovation program".

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

§ 369-ii. 1332 state innovation program. 1. Authorization. Notwithstanding section three hundred sixty-nine-gg of this title, subject to federal approval, if it is in the financial interest of the state to do so, the commissioner of health is authorized, with the approval of the director of the budget, to establish a 1332 state innovation program pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision twenty-five of section two hundred sixty-eight-c of the public health law. The commissioner of health's authority pursuant to this section is contingent upon obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an application for a waiver for state innovation. The commissioner of health shall take all actions necessary to obtain such approvals.

2. Definitions. For the purposes of this section:

(a) "Eligible organization" means an insurer licensed pursuant to article thirty-two or forty-two of the insurance law, a corporation or an organization under article forty-three of the insurance law, or an organization certified under article forty-four of the public health law, including providers certified under section forty-four hundred three-e of the public health law.

(b) "Approved organization" means an eligible organization approved by the commissioner of health to underwrite a 1332 state innovation health insurance plan pursuant to this section.

(c) "Health care services" means:

(i) the services and supplies as defined by the commissioner of health 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 of health 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;

(ii) dental and vision services as defined by the commissioner of health, and

(iii) as defined by the commissioner of health and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting.

(d) "Qualified health plan" means a health plan that meets the criteria for certification described in § 1311(c) of the patient protection and affordable care act (P.L. 111-148), and is offered to individuals through the NY State of Health, the official health Marketplace, or Marketplace, as defined in subdivision two of section two hundred sixty-eight-a of the public health law.

(e) "Basic health insurance plan" means a health plan providing health care services, separate and apart from qualified health plans, that is issued by an approved organization and certified in accordance with section three hundred sixty-nine-gg of this title.

(f) "1332 state innovation plan" means a standard health plan providing health care services, separate and apart from a qualified health plan and a basic health insurance plan, that is issued by an approved organization and certified in accordance with this section.

3. State innovation plan eligible individual. (a) A person is eligible to receive coverage for health care under this section if they:

(i) reside in New York state and are under sixty-five years of age, including individuals that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status;

(ii) are not eligible for medical assistance under title eleven of this article, excluding eligibility for limited medical assistance for the treatment of an emergency medical condition authorized pursuant to 42 U.S.C. 1396, or for the child health insurance plan described in title one-A of article twenty-five of the public health law;

(iii) are not eligible for minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Service Code of 1986, or is eligible for an employer-sponsored plan that is not affordable, in accordance with section 5000A(f) of such code; and

(iv) have household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; provided, however, that MAGI eligible noncitizens lawfully present in the United States and individuals that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this section.

(b) Subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this section who but for their eligibility under this section would be eligible for coverage pursuant to subparagraphs two or four of paragraph (b) of subdivision one of section three hundred sixty-six of this article, shall be administratively enrolled, as defined by the commissioner of health, in medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

(c) Subject to federal approval, an individual who is eligible for and receiving coverage for health care services pursuant to this section is eligible to continue to receive health care services pursuant to this section during the individual's pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if

such change would render the pregnant individual ineligible to receive health care services pursuant to this section.

(d) For the purposes of this section, 1332 state innovation program eligible individuals are prohibited from being treated as qualified individuals under section 1312 of the Affordable Care Act and as eligible individuals under section 1331 of the ACA and enrolling in qualified health plan through the Marketplace or standard health plan through the Basic Health Program.

4. Enrollment. (a) Subject to federal approval, the commissioner of health is authorized to establish an application and enrollment procedure for prospective enrollees. Such procedure will include a verification system for applicants, which must be consistent with 42 USC § 1320b-7.

(b) Such procedure shall allow for continuous enrollment for enrollees to the 1332 state innovation program where an individual may apply and enroll for coverage at any point.

(c) Upon an applicant's enrollment in a 1332 state innovation plan, coverage for health care services pursuant to the provisions of this section shall be retroactive to the first day of the month in which the individual was determined eligible, except in the case of program transitions within the Marketplace.

(d) A person who has enrolled for coverage pursuant to this section, and who loses eligibility to enroll in the 1332 state innovation program for a reason other than lack of state residence, providing inaccurate information that would affect eligibility when requesting or renewing health coverage pursuant to this section, or failure to make an applicable premium payment, before the end of a twelve month period beginning on the effective date of the person's initial eligibility for coverage, or before the end of a twelve month period beginning on the date of any subsequent determination of eligibility, shall have their eligibility for coverage continued until the end of such twelve month period, provided that the state receives federal approval for using funds under an approved 1332 waiver.

5. Premiums. Subject to federal approval, the commissioner of health shall establish premium payments enrollees in a 1332 state innovation plan shall pay to approved organizations for coverage of health care services pursuant to this section. Such premium payments shall be established in the following manner:

(a) up to fifteen dollars monthly for an individual with a household income above two hundred percent of the federal poverty line but at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and

(b) no payment is required for individuals with a household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size.

6. Cost-sharing. The commissioner of health shall establish cost-sharing obligations for enrollees, subject to federal approval, including childbirth and newborn care consistent with the medical assistance program under title eleven of this article. There shall be no cost-sharing obligations for enrollees for:

(a) dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision two of this section; and

(b) services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision two of this section.

7. Rates of payment. (a) The commissioner of health shall select the contract with an independent actuary to study and recommend appropriate reimbursement methodologies for the cost of health care service coverage pursuant to this section. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of reimbursement methodologies, including but not limited to; the adequacy of rates of payment in relation to the population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards.

(b) Upon consultation with the independent actuary and entities representing approved organizations, the commissioner of health shall develop reimbursement methodologies and fee schedules for determining rates of payment, which rates shall be approved by the director of the division of the budget, to be made by the department to approved organizations for the cost of health care services coverage pursuant to this section. Such reimbursement methodologies and fee schedules may include provisions for capitation arrangements.

(c) The commissioner of health shall have the authority to promulgate regulations, including emergency regulations, necessary to effectuate the provisions of this subdivision.

(d) The department of health shall require the independent actuary selected pursuant to paragraph (a) of this subdivision to provide a complete actuarial report, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates for the 1332 state innovation plan authorized under this section. Such report shall be provided annually to the temporary president of the senate and the speaker of the assembly.

8. An individual who is lawfully admitted for permanent residence, permanently residing in the United States under color of law, or who is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15), and who would be ineligible for medical assistance under title eleven of this article due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall be considered to be ineligible for medical assistance for purposes of paragraphs (b) and (c) of subdivision three of this section.

9. Reporting. The commissioner of health shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall include, at a minimum, an analysis of the 1332 state innovation program and its impact on the financial interest of the state; its impact on the Marketplace including enrollment and premiums; its impact on the number of uninsured individuals in the state; its impact on the Medicaid global cap; and the demographics of the 1332 state innovation program enrollees including age and immigration status.

10. Severability. If the secretary of health and human services or the secretary of the treasury do not approve any provision of the application for a state innovation waiver, such decision shall in no way affect or impair any other provisions that the secretaries may approve under this section.

§ 4. The state finance law is amended by adding a new section 98-d to read as follows:

§ 98-d. 1332 state innovation program fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special fund to be known as the "1332 state innovation program fund".

2. Such fund shall be kept separate and shall not be commingled with any other funds in the custody of the state comptroller and the commissioner of taxation and finance.

3. Such fund shall consist of moneys transferred from the federal government pursuant to 42 U.S.C. 18052 and an approved 1332 state innovation program waiver application for the purpose implementing the state plan under the 1332 state innovation program, established pursuant to section three hundred sixty-nine-ii of the social services law.

4. Upon federal approval, all moneys in such fund shall be used to implement and operate the 1332 state innovation program, pursuant to section three hundred sixty-nine-ii of the social services law, except to the extent that the provisions of such section conflict or are inconsistent with federal law, in which case the provisions of such federal law shall supersede such state law provisions.

§ 5. Subparagraph (1) of paragraph (g) of subdivision 1 of section 366 of the social services law, as amended by section 45 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(1) Applicants and recipients who are lawfully admitted for permanent residence, or who are permanently residing in the United States under color of law, or who are non-citizens in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15); who are MAGI eligible pursuant to paragraph (b) of this subdivision; and who would be ineligible for medical assistance coverage under subdivisions one and two of section three hundred sixty-five-a of this title solely due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall only be eligible for assistance under this title if enrolled in a standard health plan offered by a basic health program established pursuant to section three hundred sixty-nine-gg of this article **or a standard health plan offered by a 1332 state innovation program established pursuant to section three hundred sixty-nine-ii of this article** if such program is established and operating.

§ 6. 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.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 2023; provided that section three of this act shall be contingent upon the commissioner of health obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an application for a waiver for state innovation pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision 25 of section 268-c of the public health law. The department of health shall notify the legislative bill drafting commission upon the occurrence of approval of the waiver program in order that the commission may maintain an accurate and timely data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART I

Section 1. Subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medical expenditures, as amended by section 8 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

(i) the amendments to paragraph (b) and subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law made by section forty-one-b of this act shall expire and be repealed April 1, [~~2023~~] 2027;

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. The opening paragraph of subparagraph (i) of paragraph (d) of subdivision 6 of section 4403-f of the public health law, as added by section 5 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

Effective April first, two thousand twenty, and expiring March thirty-first, two thousand [~~twenty-two~~] twenty-seven, the commissioner shall place a moratorium on the processing and approval of applications seeking a certificate of authority as a managed long term care plan pursuant to this section, including applications seeking authorization to expand an existing managed long term care plan's approved service area or scope of eligible enrollee populations. Such moratorium shall not apply to:

§ 5. Section 4403-f of the public health law is amended by adding a new subdivision 6-a to read as follows:

6-a. Performance standards and procurement. (a) On or before October first, two thousand twenty-four, each managed long term care plan that has been issued a certificate of authority pursuant to this section shall have demonstrated experience operating a managed long term care plan. The managed long term care plan shall sufficiently demonstrate success in the following performance categories:

(i) readiness to timely implement and adhere to maximum wait time criteria for key categories of service in accordance with laws, rules and regulations of the department or the center for medicare and medicaid services;

(ii) implementation of a community reinvestment plan that has been approved by the department and commits a percentage of the managed long term care plan's surplus to health related social needs and advancing health equity in the managed long term care plan's service area;

(iii) commitment to quality improvement;

(iv) accessibility and geographic distribution of network providers, taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings;

(v) demonstrated cultural and language competencies specific to the population of participants;

(vi) breadth of service area across multiple regions; and

(vii) value based care readiness and experience.

(b) The commissioner, at any time on or after October first, two thousand twenty-four, shall require a managed long term care plan that has not met the performance standards set forth in paragraph (a) of this subdivision to establish and implement a performance improvement plan acceptable to the commissioner.

§ 6. Subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law, as amended by section 1 of part GGG of chapter 59 of the laws of 2017, is amended to read as follows:

(i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a

comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social, cognitive, and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee**, including appropriate community-based referrals**. Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.

§ 6-a. Subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law, as added by section 65-c of part A of chapter 57 of the laws of 2006 and relettered by section 20 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the prospective enrollee**, including appropriate community-based referrals**.

§ 7. Intentionally omitted.

§ 8. Intentionally omitted.

§ 9. Intentionally omitted.

§ 10. Intentionally omitted.

§ 11. Intentionally omitted.

§ 12. Intentionally omitted.

§ 13. Part I of chapter 57 of the laws of 2022, providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, is amended by adding two new sections 1-a and 1-b to read as follows:

§ 1-a. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of residential health care facilities services shall be subject to a uniform rate increase of ten percent in addition to the increase contained in subdivision 1 of section 1 of this part, subject to the approval of the commissioner of the department of health and the director of the budget. Such rate increase shall be subject to federal financial participation.

§ 1-b. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of assisted living programs as defined by paragraph (a) of subdivision one of section 461-l of the social services law shall be subject to a uniform rate increase of ten percent in addition to the increase contained in section one of this part, subject to the approval of the commissioner of the department of health and the director of the budget. Such rate increase shall be subject to federal financial participation.

§ 14. Intentionally omitted.

§ 15. Intentionally omitted.

§ 16. Intentionally omitted.

§ 17. Intentionally omitted.

§ 18. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023; provided, however, that:

(a) the amendments to section 4403-f of the public health law made by sections four through six-a of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

(b) the amendments to subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law made by section six of this act shall be subject to the expiration and reversion of such subparagraph pursuant to subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, as amended, when upon such date the provisions of section six-a of this act shall take effect.

PART J

Intentionally Omitted

PART K

Section 1. Subparagraphs 1 and 2 of paragraph (e) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, clause (iii) of subparagraph 2 as amended by chapter 477 of the laws of 2022, are amended to read as follows:

(1) is an inmate or patient in an institution or facility wherein medical assistance may not be provided in accordance with applicable federal or state requirements, except for persons described in subparagraph ten of paragraph (c) of this subdivision or subdivision one-a or subdivision one-b of this section; **or except for standard coverage under this title provided to persons in a correctional institution or facility permitted by a waiver authorized pursuant to section eleven hundred fifteen of the federal social security act; if, so long as, and to the extent federal financial participation is available for such expenditures provided pursuant to such waiver;** or

(2) is a patient in a public institution operated primarily for the treatment of tuberculosis or care of the mentally disabled, with the exception of: (i) a person sixty-five years of age or older and a patient in any such institution; (ii) a person under twenty-one years of age and receiving in-patient psychiatric services in a public institution operated primarily for the care of the mentally disabled; (iii) a patient in a public institution operated primarily for the care of individuals with developmental disabilities who is receiving medical care or treatment in that part of such institution that has been approved pursuant to law as a hospital or nursing home; (iv) a patient in an institution operated by the state department of mental hygiene, while under care in a hospital on release from such institution for the purpose of receiving care in such hospital; [~~or~~] (v) is a person residing in a community residence or a residential care center for adults**; or (vi) certain services provided to persons in an institution for mental diseases permitted by a waiver authorized pursuant to section eleven hundred fifteen of the federal social security act; if, so long as, and to the extent federal financial participation is available for such expenditures provided pursuant to such waiver**.

§ 2. Section 366 of the social services law is amended by adding a new subdivision 2-a to read as follows:

2-a. The office of children and family services, in collaboration with the department of health and the office of mental health, shall convene a workgroup of individuals with expertise in the child welfare and foster care systems, as well as expertise in medical assistance and institutions for mental diseases.

(a) the following members, or their designees, shall participate in the workgroup: (i) the commissioner of the office of children and family services; (ii) the commissioner of the department of health; and (iii) the commissioner of the office of mental health. Additional members of the workgroup shall include, but are not limited to, representatives of qualified residential treatment programs; representatives of local social services districts responsible for the placement of youth in foster care; and nongovernmental organizations that provide services and support to children and youth in the child welfare and foster care systems;

(b) the workgroup's focus shall include, but not be limited to: identifying funding sources for the provision of standard coverage under this title to children and youth in qualified residential treatment programs or institutions for mental disease; identifying barriers to access and accessibility of services until this title for children or youth in qualified residential treatment programs or institutions for mental disease following the expiration of any waiver authorized pursuant to section eleven hundred fifteen of the federal social security act; potential solutions to identified barriers to access; determining whether regulatory or statutory changes could promote access to standard coverage under this title; evaluating the effectiveness of current health insurance coverage for children in qualified residential treatment programs or institutions for mental diseases; making recommendations to improve the quality and effectiveness of that coverage; and measuring and evaluating the progress of the state to ensure health insurance coverage for children in qualified residential treatment programs or institutions for mental diseases;

(c) the workgroup shall convene no later than one hundred twenty days following the effective date of this subdivision;

(d) the workgroup shall meet as frequently as its business may require and members of the workgroup shall receive no compensation for their participation; and

(e) the office of children and family services shall provide a written report summarizing the findings and recommendations from the workgroup to the governor, the speaker of the assembly and the temporary president of the senate no later than one year following the convening of the workgroup. The report shall be posted on the office of children and family services website.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023; provided, however, that the provisions of section two of this act shall expire and be deemed repealed two years after such effective date.

PART L

Section 1. Section 3241 of the insurance law is amended by adding a new subsection (d) to read as follows:

(d)(1) For purposes of this subsection:

(A) "Free-standing ambulatory surgical center" shall mean a diagnostic and treatment center authorized pursuant to article twenty-eight of the public health law and operated independently from a hospital.

(B) "Health care plan" shall mean an insurer, a corporation organized pursuant to article forty-three of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law, 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, that issues a health insurance policy or contract or that arranges for care and services for members under a contract with the department of health with a network of health care providers and utilizes site of service review to determine coverage for services delivered by participating providers.

(C) "Hospital-based outpatient clinic" shall mean a clinic authorized pursuant to article twenty-eight of the public health law and listed on a hospital's operating certificate.

(D) "Site of service review" shall mean criteria applied by a health care plan for purposes of determining whether a procedure will be covered for a given insured or enrollee when rendered by a network provider at a hospital-based outpatient clinic rather than a free-standing ambulatory surgical center.

(2) Site of service review shall be deemed utilization review in accordance with and subject to the requirements and protections of article forty-nine of this chapter and article forty-nine of the public health law, including the right to internal and external appeal of denials related to site of service.

(3) Site of service review shall prioritize patient health and safety, patient choice of health care provider, and access to care and shall not be based solely on cost.

(4) A health care plan shall have adequate free-standing ambulatory surgical center providers to meet the health needs of insureds and enrollees and to provide an appropriate choice of providers sufficient to render the services covered under the policy or contract.

(5) Except as provided in paragraph six of this subsection, starting January first, two thousand twenty-four, a health care plan shall provide notice disclosing and clearly explaining the site of service review to:

(A) policyholders, contract holders, insureds, and enrollees and prospective policyholders, contract holders, insureds, and enrollees at the time of plan and policy or contract selection. This disclosure shall include a statement that site of service review may limit the settings in which services covered under the policy or contract may be provided and render a participating provider unable to perform a service and shall disclose to insureds or enrollees any quality or cost differential, including differences in out-of-pocket costs, between the hospital-based outpatient clinic and the free-standing ambulatory surgical center when services at a hospital-based outpatient clinic are requested, or at any other time upon the insured's or enrollee's request. Provider directories shall also indicate when health care plan site of service review may limit the scope of services that will be covered when delivered by a participating provider;

(B) participating providers at least ninety days prior to implementation. A health care plan shall also inform providers of the process for requesting coverage of a service in a hospital-based outpatient clinic setting, including the right to request a real time clinical peer to peer discussion as part of the authorization process; and

(C) the superintendent and, as applicable, to the commissioner of health, at least forty-five days prior to notifying policyholders,

contract holders, insureds and enrollees and prospective policyholders, contract holders, insureds and enrollees and participating providers in accordance with this subsection. Such notice to the superintendent and, as applicable, to the commissioner of health, shall include draft communications to the foregoing persons for purposes of complying with this subsection.

(6) A health care plan that has implemented site of service review prior to January first, two thousand twenty-four shall provide the disclosures set forth in paragraph five of this subsection at the beginning of the open enrollment period for individual health insurance policies and contracts, and for group health insurance policies and contracts, prior to issuance, renewal, or January first, two thousand twenty-four, whichever is earlier.

(7) Starting January first, two thousand twenty-four, at a minimum, a health care plan shall approve a service covered under the policy or contract and requested to be performed by a network provider at a hospital-based outpatient clinic in the following situations:

(A) the procedure cannot be safely performed in a free-standing ambulatory surgical center due to the insured's or enrollee's health condition or the health care services;

(B) there is not sufficient free-standing ambulatory surgical center capacity in the insured's or enrollee's geographic area; or

(C) the provision of health care services at a free-standing ambulatory surgical center would result in undue delay.

(8) Starting January first, two thousand twenty-four, site of service clinical review criteria developed by health care plans shall also take into consideration whether:

(A) the insured's or enrollee's in-network treating physician recommends that the service be provided at a hospital-based outpatient clinic;

(B) the insured's in-network treating physician is not credentialed or does not have privileges at a free-standing ambulatory surgical center; or

(C) the insured has an established relationship with an in-network treating physician who performs the requested service in a hospital-based outpatient clinic.

§ 2. This act shall take effect April 1, 2023.

PART M

Section 1. Paragraph (b) of subdivision 7 of section 2802 of the public health law, as amended by section 87 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(b) At such time as the commissioner's written approval of the construction is granted, each applicant shall pay the following additional fee:

(i) for hospital, nursing home and diagnostic and treatment center applications that require approval by the council, the additional fee shall be [~~fifty-five~~] sixty hundredths of one percent of the total capital value of the application, provided however that applications for construction of a safety net diagnostic and treatment center, as defined in paragraph (c) of subdivision sixteen of section twenty-eight hundred one-a of this article, shall be subject to a fee of forty-five hundredths of one percent of the total capital value of the application; and

(ii) for hospital, nursing home and diagnostic and treatment center applications that do not require approval by the council, the additional fee shall be [~~thirty~~] thirty-five hundredths of one percent of the total capital value of the application, provided however that safety net diagnostic and treatment center applications, as defined in paragraph (c) of subdivision sixteen of section twenty-eight hundred one-a of this article, shall be subject to a fee of twenty-five hundredths of one percent of the total capital value of the application.

§ 2. Section 3605 of the public health law is amended by adding two new subdivisions 1-a and 1-b to read as follows:

1-a. Core public health services, as defined in section six hundred two of this chapter, when provided in the home by the local health department of a county or of the city of New York, shall not require licensure under this section, provided that such services shall not include: home health aide services; personal care services; or nursing services that require more than minimal patient contact. For the purposes of this subdivision the term "minimal patient contact" includes, but is not limited to, providing assessments of new mothers and infants, direct observation, and lead screening. Patient contact shall be considered more than minimal if it requires more than six patient visits. Core public health services that may be provided without a license pursuant to this subdivision include but are not limited to: immunizations; testing for tuberculosis and observation of tuberculosis self-directed therapy; verbal assessment, counseling and referral services; and such other services as may be determined by the department.

1-b. Core public health services, as defined in section six hundred two of this chapter, when provided by local health departments in the home as authorized under subdivision one-a of this section, may be eligible for reimbursement under title XIX of the federal Social Security Act provided that the services provided meet federal and state requirements for such reimbursement.

§ 3. This act shall take effect immediately. 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 N

Section 1. Section 366 of the social services law is amended by adding a new subdivision 16 to read as follows:

16. (a) The commissioner of health is authorized to submit the appropriate waivers and/or any other required requests for federal approval, including but not limited to, those authorized in section eleven hundred fifteen of the federal social security act, in order to establish expanded medical assistance eligibility for working disabled individuals. Such waiver applications shall be executed consistent with paragraphs (b), (c), (d) and (e) of this subdivision, to the extent those sections comply with the requirements of section eleven hundred fifteen of the federal social security act. Notwithstanding subparagraphs five and six of paragraph (c) of subdivision one of this section and subdivision twelve of section three hundred sixty-seven-a of this title, or any other provision of law to the contrary, if granted such waiver, the commissioner of health may authorize eligible persons to receive medical assistance pursuant to the waiver if, for so long as, and to the extent that, financial participation is available therefor. The waiver applica-

tion shall provide for thirty thousand persons to be eligible to participate in such waiver.

(b) Individuals eligible for participation in such waiver shall:

(i) be a disabled individual, defined as having a medically determinable impairment of sufficient severity and duration to qualify for benefits under Titles II or XVI of the social security act;

(ii) be at least sixteen years of age;

(iii) be otherwise eligible for medical assistance benefits, but for earnings and/or resources in excess of the allowable limit;

(iv) have net available income, determined in accordance with subdivision two of this section, that does not exceed two thousand two hundred fifty percent of the applicable federal poverty line, as defined and updated by the United States department of health and human services;

(v) have resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, other than retirement accounts, that do not exceed three hundred thousand dollars;

(vi) contribute to the cost of medical assistance provided pursuant to this paragraph in accordance with paragraph (d) of this subdivision; and

(vii) meet such other criteria as may be established by the commissioner as may be necessary to administer the provisions of this subdivision in an equitable manner.

(c) An individual at least sixteen years of age who: is employed; ceases to be eligible for participation in such waiver pursuant to paragraph (b) of this subdivision because the person, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be certified as disabled under the social security act; continues to have a severe medically determinable impairment, to be determined in accordance with applicable federal regulations; and contributes to the cost of medical assistance provided pursuant to this paragraph in accordance with paragraph (d) of this subdivision, shall be eligible for participation in such waiver. For purposes of this paragraph, a person is considered to be employed if the person is earning at least the applicable minimum wage under section six of the federal fair labor standards act and working at least forty hours per month.

(d) Prior to receiving medical assistance pursuant to such waiver, a person whose net available income is greater than or equal to two hundred fifty percent of the applicable federal poverty line shall pay a monthly premium, in accordance with a procedure to be established by the commissioner. The amount of such premium for a person whose net available income is greater than or equal to two hundred fifty percent of the applicable federal poverty line, but less than three hundred percent of the applicable federal poverty line shall be three hundred and forty-seven dollars. The amount of such premium for a person whose net available income is greater than or equal to three hundred percent of the applicable federal poverty line, but less than four hundred percent of the applicable federal poverty line shall be five hundred eighteen dollars. The amount of such premium for a person whose net available income is greater than or equal to four hundred percent of the applicable federal poverty line, but less than five hundred percent of the applicable federal poverty line shall be seven hundred and seventy-nine dollars. The amount of such premium for a person whose net available income is equal to or greater than five hundred percent of the applicable federal poverty line shall be one thousand four hundred and forty-eight dollars. No premium shall be required from a person whose net

available income is less than two hundred fifty percent of the applicable federal poverty line.

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

§ 2. This act shall take effect on January 1, 2025.

PART O

Section 1. Subdivisions 1, 17 and 18 of section 1399-aa of the public health law, subdivision 1 as amended by chapter 13 of the laws of 2003, subdivisions 17 and 18 as added by section 2 of part EE of chapter 56 of the laws of 2020, are amended to read as follows:

1. "Enforcement officer" means the enforcement officer designated pursuant to article thirteen-E of this chapter to enforce such article and hold hearings pursuant thereto; provided that in a city with a population of more than one million it shall also mean an officer or employee or any agency of such city that is authorized to enforce any local law of such city related to the regulation of the sale of cigarettes, tobacco products, or vapor products to minors.

17. "Vapor products" means any noncombustible liquid or gel, regardless of the presence of nicotine therein, that is manufactured into a finished product for use in an electronic [~~cigarette, including any~~] device that delivers vapor which is inhaled, including any refill, cartridge, device or component thereof that contains or is intended to be used with such noncombustible liquid or gel. "Vapor product" shall not include any device, or any component thereof, that does not contain such noncombustible liquid or gel, or any product approved by the United States [~~food and drug administration~~] Food and Drug Administration as a drug or medical device, or manufactured and dispensed pursuant to [~~title five-A of article thirty-three of this chapter~~] article three, four or five of the cannabis law.

18. "Vapor products dealer" means a person licensed by the commissioner of taxation and finance to sell vapor products [~~in this state~~], or a person or business required to obtain such license.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 6. Subdivision 2 and paragraph (f) of subdivision 3 of section 1399-ee of the public health law, as amended by section 6 of part EE of chapter 56 of the laws of 2020, are amended to read as follows:

2. If the enforcement officer determines after a hearing that a violation of this article has occurred, [~~he or she~~] or that a state or local health official was denied access to a retail store including all product display and storage areas, for the purpose of evaluating compliance with this article, they shall impose a civil penalty of a minimum of three hundred dollars, but not to exceed one thousand five hundred dollars for a first violation, and a minimum of one thousand dollars, but not to exceed two thousand five hundred dollars for each subsequent violation, unless a different penalty is otherwise provided in this article. The enforcement officer shall advise the retail dealer that upon the accumulation of three or more points pursuant to this section

the department of taxation and finance shall suspend the dealer's registration. If the enforcement officer determines after a hearing that a retail dealer was selling tobacco **or vapor** products while their registration was suspended or permanently revoked pursuant to subdivision three or four of this section, [~~he or she~~] **they** shall impose a civil penalty of twenty-five hundred dollars.

(f) Surcharge. A [~~two~~] **four** hundred [~~fifty~~] dollar surcharge to be assessed for every violation will be made available to enforcement officers and shall be used solely for compliance checks to be conducted to determine compliance with this section.

§ 7. Subdivision 1 of section 1399-ff of the public health law, as amended by chapter 100 of the laws of 2019, is amended to read as follows:

1. Where a civil penalty for a particular incident has not been imposed or an enforcement action regarding an alleged violation for a particular incident is not pending under section thirteen hundred ninety-nine-ee of this article, a parent or guardian of a person under twenty-one years of age to whom tobacco products, herbal cigarettes [~~or electronic cigarettes~~]**, or vapor products** are sold or distributed in violation of this article may submit a complaint to an enforcement officer setting forth the name and address of the alleged violator, the date of the alleged violation, the name and address of the complainant and the person under twenty-one years of age, and a brief statement describing the alleged violation. The enforcement officer shall notify the alleged violator by certified or registered mail, return receipt requested, that a complaint has been submitted, and shall set a date, at least fifteen days after the mailing of such notice, for a hearing on the complaint. Such notice shall contain the information submitted by the complainant.

§ 8. Subdivision 1 of section 1399-gg of the public health law, as amended by chapter 513 of the laws of 2004, is amended to read as follows:

1. All tobacco cigarettes **or vapor products** sold or offered for sale by a retail dealer shall be sold or offered for sale in the package, box, carton or other container provided by the manufacturer, importer, or packager which bears all health warnings required by applicable law.

§ 9. The opening paragraph and subdivisions 2 and 3 of section 1399-hh of the public health law, as amended by section 8 of part EE of chapter 56 of the laws of 2020, are amended to read as follows:

The commissioner shall develop, plan and implement a comprehensive program to reduce the prevalence of tobacco [~~use, and vapor product, intended or reasonably expected to be used with or for the consumption of nicotine,~~] **and vapor product** use particularly among persons less than twenty-one years of age. This program shall include, but not be limited to, support for enforcement of this article.

2. The commissioner shall distribute such monies as are made available for such purpose to enforcement officers and, in so doing, consider the number of licensed vapor products dealers **or sellers,** and retail locations registered to sell tobacco products within the jurisdiction of the enforcement officer and the level of proposed activities. **For the purposes of this section, seller means a person, sole proprietorship, corporation, limited liability company, partnership or other enterprise that manufactures, distributes, sells or offers to sell, whether through retail or wholesale, or exchanges or offers to exchange for any form of consideration, cigarettes, tobacco products, or vapor products. This definition is without regard to the quantity of cigarettes, tobacco**

products, or vapor products manufactured, distributed, sold, offered for sale, exchanged, or offered for exchange.

3. Monies made available to enforcement officers pursuant to this section shall only be used for local tobacco and vapor product[~~, intended or reasonably expected to be used with or for the consumption of nicotine,~~] enforcement activities approved by the commissioner.

§ 10. Subdivision 2 of section 1399-ii of the public health law, as amended by section 12 of part EE of chapter 56 of the laws of 2020, is amended to read as follows:

2. The department shall support tobacco and vapor product use prevention and control activities including, but not limited to:

(a) Community programs to prevent and reduce tobacco use through local involvement and partnerships;

(b) School-based programs to prevent and reduce tobacco use and use of vapor products;

(c) Marketing and advertising to discourage tobacco and vapor product [~~and liquid nicotine~~] use especially among consumers historically targeted by tobacco and vapor product advertising and manufacturers;

(d) Nicotine cessation programs for youth and adults;

(e) Special projects to reduce the disparities in smoking prevalence among various populations;

(f) Restriction of youth access to tobacco products and vapor products;

(g) Surveillance of smoking and vaping rates; and

(h) Any other activities determined by the commissioner to be necessary to implement the provisions of this section.

Such programs shall be selected by the commissioner through an application process which takes into account whether a program utilizes methods recognized as effective in reducing [~~nicotine~~] tobacco or vapor product use. Eligible applicants may include, but not be limited to, a health care provider, schools, a college or university, a local public health department, a public health organization, a health care provider organization, association or society, municipal corporation, or a professional education organization.

§ 11. Section 1399-ii-1 of the public health law, as added by section 11 of part EE of chapter 56 of the laws of 2020, is amended to read as follows:

§ 1399-ii-1. [~~Electronic cigarette and vaping~~] Vapor product prevention, awareness and control program. The commissioner shall, in consultation and collaboration with the commissioner of education, establish and develop [~~an electronic cigarette and vaping~~] a vapor product prevention, control and awareness program within the department. Such program shall be designed to educate students, parents and school personnel about the health risks associated with vapor product use and control measures to reduce the prevalence of vaping, particularly among persons less than twenty-one years of age. Such program shall include, but not be limited to, the creation of age-appropriate instructional tools and materials that may be used by all schools, and marketing and advertising materials to discourage [~~electronic cigarette~~] vapor product use.

§ 12. Intentionally omitted.

§ 13. Intentionally omitted.

§ 14. Subdivision 6 of section 1399-ll of the public health law, as amended by section 3 of part EE of chapter 56 of the laws of 2020, is amended to read as follows:

6. The attorney general may bring an action to recover the civil penalties provided by subdivision five of this section and for such other relief as may be deemed necessary. In addition, the corporation counsel of any political subdivision that imposes a tax on cigarettes or vapor products [~~intended or reasonably expected to used with or for the consumption of nicotine~~] may bring an action to recover the civil penalties provided by subdivision five of this section and for such other relief as may be deemed necessary with respect to any cigarettes or vapor products [~~intended or reasonably expected to be used with or for the consumption of nicotine~~] shipped, caused to be shipped or transported in violation of this section to any person located within such political subdivision. All civil penalties obtained in any such action shall be retained by the state or political subdivision bringing such action[~~, provided that no person shall be required to pay civil penalties to both the state and a political subdivision with respect to the same violation of this section~~].

§ 15. Intentionally omitted.

§ 16. Section 1399-mm-1 of the public health law, as added by section 1 of part EE of chapter 56 of the laws of 2020, is amended to read as follows:

§ 1399-mm-1. Sale of flavored products prohibited. 1. For the purposes of this section "flavored" shall mean any vapor product [~~intended or reasonably expected to be used with or for the consumption of nicotine,~~] with a [~~distinguishable~~] taste [~~or~~]~~,~~ aroma~~, or sensation, distinguishable by an ordinary consumer~~, other than the taste or aroma of tobacco, imparted either prior to or during consumption of such product or a component part thereof, including but not limited to tastes or aromas relating to any fruit, chocolate, vanilla, honey, candy, cocoa, dessert, alcoholic beverage, mint, wintergreen, menthol, herb or spice, or any concept flavor that imparts a taste or aroma that is distinguishable from tobacco flavor but may not relate to any particular known flavor. A vapor product [~~intended or reasonably expected to be used with or for the consumption of nicotine,~~] shall be presumed to be flavored if a product's ~~packaging or labeling, or if the product's~~ retailer, manufacturer, or a manufacturer's agent or employee~~,~~ has made a statement or claim directed to consumers or the public, whether expressed or implied, that such product or device has a [~~distinguishable~~] taste [~~or~~]~~,~~ aroma~~, or sensation, as distinguishable by the ordinary consumer,~~ other than the taste [~~or~~]~~,~~ aroma~~, or sensation~~ of tobacco.

2. No vapor products dealer~~, seller~~, or any agent or employee of a vapor products dealer ~~or seller~~, shall sell or offer for sale [~~at retail in the state~~]~~, or exchange or offer for exchange, for any form of consideration,~~ any flavored vapor product [~~intended or reasonably expected to be used with or for the consumption of nicotine~~]~~, whether through retail or wholesale~~. ~~For the purposes of this section, seller means a person, sole proprietorship, corporation, limited liability company, partnership or other enterprise that manufactures, distributes, sells or offers to sell, whether through retail or wholesale, or exchanges or offers to exchange for any form of consideration vapor products. This definition is without regard to the quantity of vapor products manufactured, distributed, sold, offered for sale, exchanged, or offered for exchange.~~

3. ~~No vapor products dealer or seller or any agent or employee of a vapor products dealer or seller, acting in the capacity thereof, shall keep in inventory, store, stow, warehouse, process, package, ship, or distribute flavored vapor or tobacco products anywhere in, or adjacent~~

to, a place of business where vapor products are sold, offered for sale, exchanged, or offered for exchange, for any form of consideration, at retail.

4. Any vapor products dealer or seller, or any agent or employee of a vapor products dealer or seller, who violates the provisions of this section shall be subject to a civil penalty of not more than [~~one~~] three hundred dollars for each individual package of flavored vapor product [~~intended or reasonably expected to be used with or for the consumption of nicotine sold or offered for sale, provided, however, that with respect to a manufacturer, it shall be an affirmative defense to a finding of violation pursuant to this section that such sale or offer of sale, as applicable, occurred without the knowledge, consent, authorization, or involvement, direct or indirect, of such manufacturer~~] sold or offered for sale, or exchanged or offered for exchange, for any form of consideration, whether through retail or wholesale, or kept in inventory, stored, stowed, warehoused, processed, packaged, shipped, or distributed anywhere in, or adjacent to, a place of business where vapor or tobacco products are sold, offered for sale, exchanged, or offered for exchange, for any form of consideration, at retail. Violations of the provisions of this section shall be enforced pursuant to [~~section~~] sections thirteen hundred ninety-nine-ff and thirteen hundred ninety-nine-ee of this article, [~~except that any~~] provided, however, that violations of the provisions of this section may also be enforced by the commissioner; provided, further, however, that any monies obtained in any such enforcement action taken by the commissioner shall be made available to support tobacco and vapor product enforcement programs operating pursuant to section thirteen hundred ninety-nine-hh of this article. Any person may submit a complaint to an enforcement officer that a violation of this section has occurred.

[~~4. The provisions of this section shall not apply to any vapor products dealer, or any agent or employee of a vapor products dealer, who sells or offers for sale, or who possess with intent to sell or offer for sale, any flavored vapor product intended or reasonably expected to be used with or for the consumption of nicotine that the U.S. Food and Drug Administration has authorized to legally market as defined under 21 U.S.C. § 387j and that has received a premarket review approval order under 21 U.S.C. § 387j(c) et seq.~~] 5. Nothing in this section shall be construed to penalize the purchase, use, or possession of a tobacco product or vapor product by any person not engaged as a vapor products dealer, retail dealer, tobacco or vapor seller, or any agent or employee of a vapor products dealer, retail dealer, or tobacco or vapor seller.

§ 17. Intentionally omitted.

§ 18. Intentionally omitted.

§ 19. This act shall take effect September 1, 2023.

PART P

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

§ 2825-h. Health care facility transformation program: statewide V. 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 administration of available funds pursuant to such agreement, and made available pursuant to this section and appropriation. Such funds may be awarded and distributed by the department for grants to health care 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, residential facilities or day program facilities licensed or granted an operating certificate under article sixteen of the mental hygiene law, family and child service providers licensed under article twenty-nine-I of this chapter, and midwifery birth centers established pursuant to this chapter. 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. (a) Notwithstanding section 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 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. 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, improve the quality of care and to ensure financial sustainability of health care providers, and develop capacity in underserved areas of the state.

(b) For the purposes of this section the development of capacity in underserved areas shall include new construction and renovation projects in underserved areas as determined by the department. Renovation

projects shall include those intended to convert a facility to comply with applicable physical plant standards. Awards for such projects may be associated with an entity or individual seeking to operate as a health care provider, as defined by subdivision two of this section, regardless of if such entity or individual is currently a health care provider, as defined by subdivision two of this section. Awards granted for such projects shall be structured by the department in a manner to allow providers or potential providers access to the funds as soon as practicable, but may contain provisions allowing for the department to recoup the funds at a later date in time if the provider or potential provider fails to meet the goals of the project. At least fifty million dollars of the amount identified in paragraph (c) of this subdivision shall be allocated for these purposes.

(c) At least one hundred fifty million dollars of the amount appropriated pursuant to paragraph (a) of this subdivision shall be allocated exclusively for community-based health care providers, which for the purposes of this subdivision shall be defined as: a diagnostic and treatment center licensed or granted an operating certificate under article twenty-eight of this chapter; a mental health outpatient provider licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment provider licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a program licensed under article forty-one of the mental hygiene law; a community-based program funded under the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports or through a local governmental unit as defined under article forty-one of the mental hygiene law; a home care provider certified or licensed pursuant to article thirty-six of this chapter; a primary care provider; a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law; a provider of health home services as authorized under section twenty-seven hundred three of the federal protection and affordable care act; a hospice provider licensed or granted an operating certificate under article forty of this chapter; a family and child service provider licensed under article twenty-nine-I of this chapter; or a midwifery birth center established pursuant to this chapter, for the exclusive purpose of supporting the programs and services defined in this subdivision.

4. (a) Notwithstanding section 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 five hundred 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, which shall include projects related to improving cyber security.

(b) At least one hundred million dollars of the amount appropriated pursuant to paragraph (a) of this subdivision shall be allocated exclusively for community-based health care providers, which for the purposes of this subdivision shall be defined as: a diagnostic and treatment center licensed or granted an operating certificate under article twenty-eight of this chapter; a mental health outpatient provider licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment provider licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a program licensed under article forty-one of the

mental hygiene law; a community-based program funded under the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports or through a local governmental unit as defined under article forty-one of the mental hygiene law; a home care provider certified or licensed pursuant to article thirty-six of this chapter; a primary care provider; a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law; a provider of health home services as authorized under section twenty-seven hundred three of the federal protection and affordable care act; a hospice provider licensed or granted an operating certificate under article forty of this chapter; a family and child service provider licensed under article twenty-nine-I of this chapter; or a midwifery birth center established pursuant to this chapter, for the exclusive purpose of supporting the programs and services defined in this subdivision.

5. Selection of awards made by the department pursuant to subdivisions three and four 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.

6. 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 five 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, 2023.

PART Q

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

(kk) community health worker services for children under age twenty-one, and for adults with health-related social needs, when such services are recommended by a physician or other health care practitioner authorized under title eight of the education law, and provided by qualified community health workers, as determined by the commissioner of health; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

§ 2. Clause (C) of subparagraph (ii) of paragraph (f) of subdivision 2-a of section 2807 of the public health law, as amended by section 43 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(C) [~~individual psychotherapy~~] services provided by licensed social workers, licensed mental health counselors and licensed marriage and family therapists, in accordance with licensing criteria set forth in applicable regulations[~~, to persons under the age of twenty-one and to persons requiring such services as a result of or related to pregnancy or giving birth~~]; and

§ 3. This act shall take effect January 1, 2024.

PART R

Section 1. Subdivision 2 of section 365-a of the social services law is amended by adding two new paragraphs (kk) and (ll) to read as follows:

(kk) care and services of nutritionists and dietitians certified pursuant to article one hundred fifty-seven of the education law acting within their scope of practice.

(ll) Chronic Disease Self-Management Program for persons diagnosed with arthritis when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife and provided by qualified educators, as determined by the commissioner of health, who is affiliated with an organization delivering the program under Self-Management Resource Center licensure, or a successor national organization, provided, however, that the provisions of this paragraph shall not apply unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

§ 2. Clause (A) of subparagraph (ii) of paragraph (f) of subdivision 2-a of section 2807 of the public health law, as amended by section 43 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(A) services provided in accordance with the provisions of paragraphs (q) [~~and~~], (r), and (ll) of subdivision two of section three hundred sixty-five-a of the social services law; and

§ 3. This act shall take effect July 1, 2023; provided, however, that paragraph (ll) of subdivision 2 of section 365-a of the social services law added by section one of this act and section two of this act, shall take effect October 1, 2023.

PART S

Section 1. Subdivision 1 of section 3001 of the public health law, as amended by chapter 804 of the laws of 1992, is amended to read as follows:

1. "Emergency medical service" means [~~initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies~~] a coordinated system of healthcare delivery that responds to the needs of sick and injured adults and children, by providing: essential care at the scene of an emergency, non-emergency, specialty need or public event; community education and prevention programs; mobile integrated healthcare programs; ground and air ambulance services; centralized access and emergency medical dispatch; training for emergency medical services practitioners; medical first response; mobile trauma care systems; mass

casualty management; medical direction; or quality control and system evaluation procedures.

§ 2. Section 3002 of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-a. The state emergency medical services council shall advise and assist the commissioner on such issues as the commissioner may require related to the provision of emergency medical service, specialty care, designated facility care, and disaster medical care. This shall include, but shall not be limited to, the recommendation, periodic revision, and application of rules and regulations, appropriateness review standards, treatment protocols, workforce development, and quality improvement standards. The state emergency medical services council shall meet at least three times per year or more frequently at the request of the chairperson or department and approved by the commissioner.

§ 2-a. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. The public health law is amended by adding a new section 3004 to read as follows:

§ 3004. Emergency medical services system and agency performance standards. 1. The state emergency medical services council, in collaboration and with final approval of the department, shall create an emergency medical services system and agency performance standards (hereinafter referred to as "performance standards") for the purpose of sustaining and evolving a reliable emergency medical services system including but not limited to emergency medical services agencies and any facility or agency that dispatches or accepts emergency medical services resources.

2. The performance standards may include but shall not be limited to: safety initiatives, emergency vehicle operations, operational competencies, planning, training, onboarding, workforce development and engagement, survey responses, leadership and other standards and metrics as determined by the state emergency medical services council, with approval of the department, to promote positive patient outcomes, safety, provider retention and emergency medical services system sustainability throughout the state.

3. The performance standards shall require each emergency medical services agency, dispatch agency or facility that accepts emergency medical services resources to perform regular and periodic review of the performance standards and its metrics, perform surveys, identification of agency deficiencies and strengths, development of programs to improve agency metrics, strengthen system sustainability and operations, and improve the delivery of patient care.

4. The department, after consultation with the state emergency medical services council, may contract for services with subject matter experts to assist in the oversight of the performance standards statewide.

5. Emergency medical services agencies that do not meet the performance standards set forth in this section may be subject to enforcement actions, including but not limited to revocation, suspension, performance improvement plans, or restriction from specific types of response including but not limited to suspension of ability to respond to requests for emergency medical assistance or to perform emergency medical services.

§ 5. The public health law is amended by adding a new section 3018 to read as follows:

§ 3018. Statewide comprehensive emergency medical service system plan. 1. The state emergency medical services council, in collaboration and

with final approval of the department, shall develop and maintain a statewide comprehensive emergency medical service system plan that shall provide for a coordinated emergency medical services system in New York state, including but not limited to:

(a) establishing a comprehensive statewide emergency medical service system, consisting of facilities, transportation, workforce, communications, and other components, to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

(b) improving the accessibility of high-quality emergency medical service;

(c) coordinating professional medical organizations, hospitals, and other public and private agencies in developing alternative delivery models whereby persons who are presently using the existing emergency department for routine, nonurgent, and primary medical care will be served appropriately; and

(d) conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of emergency medical service practitioners training throughout New York state with emphasis on regions with limited access to emergency medical services training.

2. The statewide comprehensive emergency medical service system plan shall be reviewed, updated if necessary, and published every five years on the department's website, or at such times as may be necessary to improve the effectiveness and efficiency of the state's emergency medical service system.

3. Each regional emergency medical services council shall develop and maintain a comprehensive regional emergency medical service system plan or adopt the statewide comprehensive emergency medical service system plan, to provide for a coordinated emergency medical service system within the region. Such plans shall be written in a format approved by the state emergency medical services council. Further, such plans shall be subject to review and approval by the state emergency medical services council and final approval by the department.

4. Each county shall develop and maintain a comprehensive county emergency medical service system plan that shall provide for a coordinated emergency medical service system within the county, to provide essential emergency medical services for all residents within the county. Such plan shall be written in a format approved by the state emergency medical services council. The county office of emergency medical services shall be responsible for the development, implementation, and maintenance of the comprehensive county emergency medical service system plan. Such plans, as determined by the department and the state emergency medical services council, may require review and approval by the regional emergency medical services council, the state emergency medical services council and the department. Such plan shall outline the primary responding emergency medical services agency for requests for service for each part of the county.

§ 6. The public health law is amended by adding a new section 3019 to read as follows:

§ 3019. Emergency medical service training programs. 1. The state emergency medical services council shall make recommendations to the department for the department to implement standards related to the establishment of training programs for emergency medical service systems that includes but is not limited to students, emergency medical service practitioners, emergency medical services agencies, approved educational

institutions, geographic areas, facilities, and personnel, and the commissioner shall fund such training programs in full or in part based on state appropriations. Until such time as the department announces the standards for training programs pursuant to this section, all current standards, curriculums, and requirements for students, emergency medical service practitioners, agencies, facilities, and personnel shall remain in effect.

2. The state emergency medical services council, with final approval of the department, shall establish minimum education standards, curriculums, performance metrics and requirements for all emergency medical system educational institutions. No person or educational institution shall profess to provide emergency medical services training without meeting the requirements set forth in regulation and only after approval of the department and in the geographical area determined by the department.

3. The department is authorized to provide, either directly or through contract, for local or statewide initiatives, emergency medical system training for emergency medical service practitioners and emergency medical services agency personnel, using funding including but not limited to allocations to aid to localities for emergency medical services training.

4. The department may visit and inspect any emergency medical system training program or training center operating under this article to ensure compliance with all applicable regulations and standards. The department may request the state or regional emergency medical services council's assistance to ensure the compliance, maintenance, and coordination of training programs. The department, in consultation with the state emergency medical services council, may set standards and regulations for emergency medical services educational institutions. Emergency medical services educational institutions that fail to meet applicable standards and regulations may be subject to enforcement action, including but not limited to revocation, suspension, performance improvement plans, or restriction from specific types of education.

5. Students of an emergency medical services educational institution authorized pursuant to this section, shall be considered emergency medical services students and subject to the standards established in this article, regulations promulgated pursuant to this article and all applicable standards, as if they were a licensed emergency medical services practitioner and may be subject to enforcement action as such.

§ 7. Section 3012 of the public health law is amended by adding a new subdivision 5 to read as follows:

5. It shall be a violation of this chapter, subject to civil penalties, for any person to hold themselves out as an emergency medical services practitioner who is not designated by the department pursuant to this article or otherwise lawfully authorized, to provide emergency medical services, or to attempt to become an emergency medical practitioner in an unlawful or unethical manner.

§ 8. The public health law is amended by adding a new section 3020 to read as follows:

§ 3020. Recruitment and retention. 1. The commissioner shall establish and fund within amounts appropriated, a public service campaign to recruit additional personnel into the emergency medical system fields.

2. The commissioner shall establish and fund within amounts appropriated an emergency medical system mental health and wellness program that provides resources to emergency medical service practitioners to address

the following, but is not limited to reducing burnout and preventing depression, suicide, and other negative mental health outcomes.

3. The commissioner may establish in regulation standards for the licensure of emergency medical services practitioners by the department of health.

4. The department, with the approval of the state emergency medical services council, may create or adopt additional standards, training, and criteria to become an emergency medical service practitioner credentialed to provide specialized, advanced, or other services that further support or advance the emergency medical system. The department, with approval of the state emergency medical services council may also set standards and requirements to require specialized credentials to perform certain functions in the emergency medical services system.

5. The department, with approval of the state emergency medical services council may also set standards for emergency medical system agencies to become accredited in a specific area to increase system performance and agency recognition.

§ 9. Intentionally omitted.

§ 10. Section 3032 of the public health law is REPEALED.

§ 11. The public health law is amended by adding three new sections 3032, 3033 and 3034 to read as follows:

§ 3032. Mobile integrated healthcare. 1. "Mobile integrated healthcare" means the provision of patient-centered mobile resources which includes a well-organized system of services to address healthcare gaps and decrease demand on portions of the healthcare system identified by a community needs assessment, integrated into the local healthcare system working in a collaborative manner as a patient care team that may include, but not limited to, physicians, mid-level practitioners, nurses, home care agencies, emergency medical services practitioners, emergency medical services agencies and other community health team colleagues, to meet the needs of the community.

2. Emergency medical service agencies may establish a mobile integrated healthcare program, provided they meet all standards established by the department, that the delivery of such services in full or in part will not decrease the agency's ability to respond to requests for emergency assistance and the agency receives express approval from the department. The department may revoke or suspend an emergency medical service agency's approval to provide a mobile integrated healthcare program if the department finds that one or more standards established by the department have not been met. The department, in collaboration with the state emergency medical services council, shall establish criteria and standards for the operation of mobile integrated healthcare programs and mobile integrated healthcare programs shall adhere to such criteria and standards.

3. Notwithstanding sections sixty-five hundred twenty-one and sixty-nine hundred two of the education law, an emergency medical services practitioner, licensed pursuant to this article, shall be authorized to administer immunizations pursuant to a patient specific or non-patient specific standing regimen ordered by a licensed physician and pursuant to protocols adopted by the state emergency medical services council and any standards established by the department.

4. Notwithstanding sections sixty-five hundred twenty-one and sixty-nine hundred two of the education law, an emergency medical services practitioner, licensed pursuant to this article, may be authorized by the department to administer buprenorphine pursuant to a non-patient specific standing regimen ordered by a licensed physician and pursuant

to protocols adopted by the state emergency medical services council and any standards established by the department.

§ 3033. Demonstration projects. The department, in consultation with the state emergency medical services council, may allow demonstration projects related to the emergency medical system. Such demonstration projects may allow for waivers of certain parts of this article, article thirty-A of this chapter, and applicable regulations, provided the demonstration project meets any applicable standards set forth by the department.

§ 3034. Emergency medical system support services. The commissioner may promulgate regulations, with the approval of the state emergency medical services council, to set standards and criteria for basic life support first response agencies, emergency medical dispatch, and special event services, to strengthen the emergency medical service system. These organizations shall not be required to meet the standards set for determination of operating authority as outlined in section three thousand eight of this article unless otherwise determined by the state emergency medical services council and approved by the department.

§ 12. Section 6909 of the education law is amended by adding a new subdivision 11 to read as follows:

11. A certified nurse practitioner may prescribe and order a non-patient specific regimen to an emergency medical services practitioner licensed by the department of health pursuant to article thirty of the public health law, pursuant to regulations promulgated by the commissioner, and consistent with the public health law, for administering immunizations. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

§ 13. Section 6527 of the education law is amended by adding a new subdivision 11 to read as follows:

11. A licensed physician may prescribe and order a non-patient specific regimen to an emergency medical services practitioner licensed by the department of health pursuant to article thirty of the public health law, pursuant to regulations promulgated by the commissioner, and consistent with the public health law, for administering immunizations. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs.

§ 13-a. Section 3000 of the public health law, as amended by chapter 804 of the laws of 1992, is amended to read as follows:

§ 3000. Declaration of policy and statement of purpose. The furnishing of medical assistance in an emergency is a matter of vital concern affecting the public health, safety and welfare. Emergency medical services and ambulance services are essential services and shall be available to every person in the state of New York in a reliable manner. Prehospital emergency medical care, the provision of prompt and effective communication among ambulances and hospitals and safe and effective care and transportation of the sick and injured are essential public health services and shall be available to every person in the state of New York in a reliable manner.

It is the purpose of this article to promote the public health, safety and welfare by providing for certification of all advanced life support first response services and ambulance services; the creation of regional emergency medical services councils; and a New York state emergency medical services council to develop minimum training standards for certified first responders, emergency medical technicians and advanced emergency medical technicians and minimum equipment and communication

standards for advanced life support first response services and ambulance services.

§ 13-b. Subdivision 2 of section 163 of the civil service law, as amended by section 4 of part T of chapter 56 of the laws of 2010, is amended to read as follows:

2. The contract or contracts shall provide for health benefits for retired employees of the state and of the state colleges of agriculture, home economics, industrial labor relations and veterinary medicine, the state agricultural experiment station at Geneva, and any other institution or agency under the management and control of Cornell university as the representative of the board of trustees of the state university of New York, and the state college of ceramics under the management and control of Alfred university as the representative of the board of trustees of the state university of New York, and their spouses and dependent children as defined by the regulations of the president, on such terms as the president may deem appropriate, and the president may authorize the inclusion in the plan of the employees and retired employees of public authorities, public benefit corporations, school districts, special districts, district corporations, municipal corporations excluding active employees and retired employees of cities having a population of one million or more inhabitants whose compensation is or was before retirement paid out of the city treasury, or other appropriate agencies, subdivisions or quasi-public organizations of the state, including active members of volunteer fire and volunteer ambulance companies serving one or more municipal corporations pursuant to subdivision seven of section ninety-two-a of the general municipal law, and their spouses and dependent children as defined by the regulations of the president. **Notwithstanding any law or regulation to the contrary, active members of volunteer ambulance companies serving one or more municipal corporations pursuant to subdivision seven of section ninety-two-a of the general municipal law shall be eligible for health benefits regardless of the amount of funds derived from public sources.** Any such corporation, district, agency or organization electing to participate in the plan shall be required to pay its proportionate share of the expenses of administration of the plan in such amounts and at such times as determined and fixed by the president. All amounts payable for such expenses of administration shall be paid to the commissioner of taxation and finance and shall be applied to the reimbursement of funds previously advanced for such purposes. Neither the state nor any other participant in the plan shall be charged with the particular experience attributable to the employees of the participant, and all dividends or retroactive rate credits shall be distributed pro-rata based upon the number of employees of such participant covered by the plan.

§ 13-c. Paragraph 9 of subdivision c of section 40 of the retirement and social security law, as amended by chapter 525 of the laws of 1963, is amended to read as follows:

9. **Active members of volunteer ambulance companies serving one or more municipal corporations pursuant to subdivision seven of section ninety-two-a of the general municipal law.**

10. Notwithstanding any inconsistent provision of subdivision e of this section, or of this chapter or of any other law, an officer or employee in the service of the state or of a participating employer who, at the time of entering such service, was or is entitled to benefits by any other pension or retirement system maintained by the state or a political subdivision thereof, provided such benefits, exclusive of any annuity based solely on his own contributions and interest thereon, are

suspended during his active membership in the retirement system. He shall contribute to the retirement system as a new member.

§ 13-d. The public health law is amended by adding a new section 3038 to read as follows:

§ 3038. Consolidated assistance program for EMS departments. 1. For the purposes of this section, the term "funding level" shall mean the average amount of funding received over the previous two years, calculated for each emergency medical service department or contract with other municipal departments, volunteer departments, including volunteer ambulances which are based in volunteer fire departments, or non-profits for the provision of emergency medical services within their jurisdiction.

2. Notwithstanding any other provisions of this chapter or any other law, and subject to an appropriation made therefor and in accordance with the provisions of this section and with the rules and regulations promulgated by the commissioner in connection therewith, the consolidated assistance program for emergency medical service departments is hereby established for the purpose of making payments to municipalities which operate emergency medical service departments, or contract with other municipal departments, volunteer departments, including volunteer ambulances which are based in volunteer fire departments, or non-profits for the provision of emergency medical services within their jurisdiction and which do not contract, directly or indirectly, with for-profit entities for emergency medical services. The commissioner shall promulgate all necessary rules and regulations to carry out the program so that an equitable distribution of aid shall be made to such municipalities.

3. On or before the twenty-fifth day of April, June, September and November, there shall be distributed and paid to municipalities an amount equal to the moneys appropriated for the purposes of this section divided by the number of payment dates in that state fiscal year. Such amounts shall be distributed and paid pursuant to this section.

4. Amounts shall be distributed to municipalities under the consolidated assistance program for EMS departments in relative shares based on rules and regulations promulgated by the commissioner, in consultation with the New York state emergency medical services council, which shall consider for each municipality:

(a) its population and population density, prioritizing less densely populated areas where financial strain for providing service is greatest;

(b) emergency medical services call volume and call type;

(c) the percentage of its annual budget which goes to providing emergency medical services; and

(d) any other factor the commissioner, in consultation with the New York state emergency medical services council, deems relevant.

5. On the first day of the third month following the end of its fiscal year, each municipality which has received five thousand dollars or more in total funds paid pursuant to this section during the preceding fiscal year shall certify to the commissioner, pursuant to rules and regulations promulgated by the commissioner in relation thereto, that the expenditure by such municipality in such fiscal year of nonstate funds raised by the municipality for the operation of or contracting for emergency medical services was not reduced below the level of the average of the previous two years. Provided, however, that in calculating the expenditures and revenues of the municipality to determine the local maintenance of effort for the fiscal year being certified and the

expenditure level of the average of the previous two years, municipalities shall not be required to include the amount of revenues and expenditures for operation of or contracting for emergency medical services necessitated by any unforeseen event for which the municipality was officially declared a disaster area. Where a reduction in such spending or non-use has occurred, the distributions above the funding level to such municipality in the then-current state fiscal year shall be reduced by an amount equivalent to the amount of such reduction or non-use, except that no reduction to the funding level shall be taken for an amount caused by any unforeseen event for which the municipality was officially declared a disaster area. Municipalities not required to certify under this section may continue such non-certifying status, with the approval of the commissioner, if the apportionment to such municipality is increased to more than five thousand dollars but less than seven thousand dollars in any local fiscal year. For the purposes of this section, a municipality shall mean a county, city, town or village or two or more such jurisdictions acting jointly.

6. For any city, town, or village which consolidates or merges with another municipality, the resulting successor government shall file with the office of the state comptroller a certificate of any such consolidation, merger and any accompanying dissolution. If the amount which would otherwise be apportioned to the individual governments exceeds the amount which is payable to the successor government pursuant to this section, such successor government shall receive no less in consolidated assistance program for EMS department apportionments than the predecessor governments would have received in the aggregate had the merger or consolidation not occurred.

§ 13-e. The public health law is amended by adding a new section 3039 to read as follows:

§ 3039. Ambulance service assessment. 1. The department shall charge every ambulance service a uniform ambulance assessment fee, provided that the fee shall not apply to any municipal fire department, police department, or other government entity that provides emergency medical services, any ambulance service that exclusively provides emergency medical care by aircraft, or any provider required to pay an assessment on ambulance service revenue under article twenty-eight of this chapter.

2. The uniform assessment fee shall be assessed on each ambulance service covered under this section at a rate of at least five and three-quarters percent of a covered ambulance service's annual revenue, provided however that the commissioner, in consultation with the director of the division of the budget, may set such fee at a rate no greater than the maximum limit allowable under 42 C.F.R. 433.68(f). The department shall set and implement such fees using the best data available in consultation with stakeholders, including trade associations representing ambulance providers subject to such assessment, and shall update such fees on a periodic basis but at least annually.

3. All fees collected under this section shall be expended by the commissioner in a timely manner and solely for purposes of increasing medical assistance payment rates for ambulance services subject to such fees to more closely align with the average commercial rate of payment, and ensuring adequacy of the ambulance services in a region as defined by the commissioner, and to cover the reasonable administrative expenses of the department in administering the fund. Such monies shall not be used to reduce or replace other payment commitments by the state.

4. Fees collected under this section shall be held in a fund administered by the department as set forth in section ninety-seven-q-1 of the state finance law.

5. The department may impose penalties for any ambulance service that fails to pay the fee within the time required by the department.

6. Fees under this section shall be collected only if federal financial participation is available for expenditures incurred under this section. Any fees collected but not expended in a fiscal year shall remain available for expenditure in subsequent fiscal years. The department shall submit all necessary documentation for federal approval of this program, including amendments to the state plan under title XIX of the federal social security act, necessary to implement this section within one hundred eighty days of the effective date of this section.

§ 13-f. The state finance law is amended by adding a new section 97-q-1 to read as follows:

§ 97-q-1. Statewide ambulance fund; assessment of annual fees on ambulance services. 1. There is hereby established in the custody of the comptroller, a special fund to be known as the "statewide ambulance fund".

2. The fund shall consist of:

(a) all fees or penalties collected pursuant to section three thousand thirty-nine of the public health law;

(b) an amount equal to any federal financial participation revenues claimed and received by the state for eligible expenditures to be made from the fund;

(c) any appropriation or other revenue authorized by or required by law to be credited to the fund; and

(d) interest earned on any money in the fund.

3. Amounts credited to the fund shall be expended solely for Medicaid payments to ambulance services subject to fees pursuant to section three thousand thirty-nine of the public health law, and an amount not to exceed the actual and reasonable administrative expenses of the department of health to administer the fund. After payment of the administrative expenses of the department of health, the revenues of the fund shall be expended exclusively for Medicaid payments to ambulance services subject to such fees in accordance with section three thousand thirty-nine of the public health law and shall supplement not supplant existing state payments for ambulance services.

4. The department of health shall assess the fee described in section three thousand thirty-nine of the public health law only upon approval from the centers for medicare and medicaid services authorizing enhanced Medicaid payments.

5. (a) If the centers for medicare and medicaid services rescinds approval of the Medicaid payments made to ambulance services, then all monies in the fund shall be returned to the ambulance services, pro rata by contribution amount.

(b) If the commissioner of health determines the fee cannot be collected as required by section three thousand thirty-nine of the public health law, all monies in the fund shall be returned to the applicable ambulance services pro rata by contribution amount.

6. The commissioner of health may order disbursement from the fund in accordance with a schedule of payments to ambulance service providers that have contributed to such fund, as provided in section three thousand thirty-nine of the public health law.

§ 14. This act shall take effect immediately.

PART T

Section 1. The multiple residence law is amended by adding a new section 16 to read as follows:

§ 16. State rental registry and proactive inspections to identify lead hazards. 1. The division of housing and community renewal shall develop a registry for all residential dwellings with two or more units built prior to nineteen hundred eighty which, by virtue of their municipal zoning designation, are potentially eligible for rental, lease, let or hiring out, and are located within communities of concern as identified in cooperation with the department of health. Such registry shall only include qualifying residential dwellings outside New York city.

2. All residential dwellings qualifying for registration in accordance with this section must be certified as free of lead paint hazards based on inspections conducted on a tri-annual basis. Inspection certifications must be submitted to the division of housing and community renewal and local health department or their designee for recording in the rental registry.

3. The commissioner of housing and community renewal shall promulgate regulations as needed to administer, coordinate, and enforce this section, including the establishment of fines to be levied in the event of non-compliance with the requirements of this section.

4. Inspection requirements shall be based on regulation and guidance from the division of housing and community renewal with the cooperation of the department of health and may include qualifications for inspectors, minimum requirements of a compliant inspection and a process for reporting inspection results to local health departments. Minimum inspection requirements may include visual inspections for deteriorated paint and outdoor soil conditions, as well as the collection of dust wipe samples obtained in accordance with United States Environmental Protection Agency protocols for such procedures.

5. Remediation of lead-based paint hazards must be conducted in compliance with all municipal requirements and specific requirements specified in regulation.

§ 2. Paragraphs h and i of subdivision 1 of section 381 of the executive law, as added by chapter 560 of the laws of 2010, are amended and a new paragraph j is added to read as follows:

h. minimum basic training and in-service training requirements for personnel charged with administration and enforcement of the state energy conservation construction code; [~~and~~]

i. standards and procedures for measuring the rate of compliance with the state energy conservation construction code, and provisions requiring that such rate of compliance be measured on an annual basis[~~.~~]**; and**

j. procedures requiring the documentation of compliance with regulations adopted pursuant to section sixteen of the multiple residence law as a condition to issuance of a certificate of occupancy or certificate of compliance following a periodic fire safety and property maintenance inspection for multiple dwellings.

§ 3. This act shall take effect immediately; provided, however, section one of this act shall take effect eighteen months after it shall have become a law; and provided further, however, section two of this act shall take effect two years after it shall have become a law. Effective immediately, the addition, amendment, and/or repeal of any rule or regulation necessary for the timely implementation of this act on or before its effective date are authorized to be made and completed on or before such effective date.

PART U

Section 1. The general business law is amended by adding a new article 42 to read as follows:

ARTICLE 42

NEW YORK ELECTRONIC HEALTH INFORMATION PRIVACY ACT

Section 1100. Definitions.

1101. Requirements for communications to individuals.

1102. Lawfulness of processing electronic health information.

1103. Individual rights.

1104. Security.

1105. Service providers.

1106. Exemptions.

1107. Enforcement.

§ 1100. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Deidentified information" means information that cannot reasonably be used to infer information about, or otherwise be linked to a particular individual, household, or device, provided that the regulated entity or service provider that processes the information:

(a) Implements reasonable technical safeguards to ensure that the information cannot be associated with an individual, household, or device;

(b) Publicly commits to process the information only as deidentified information and not attempt to reidentify the information, except that the regulated entity or service provider may attempt to reidentify the information solely for the purpose of determining whether its deidentification processes satisfy the requirements of this section; and

(c) Contractually obligates any recipient of the deidentified to comply with all requirements of this section.

2. "Electronic health information" means any information in any electronic format or media that relates to an individual or a device that is reasonably linkable to an individual or individuals in connection with: any past, present, or future disability, physical health condition, or mental health condition; the search for or attempt to obtain health care services; any past, present, or future treatment or other health care services for a disability, physical health condition, or mental health condition; location information associated with a health care facility; or the past, present, or future payment for health care services. For the avoidance of doubt, any inference drawn or derived data about an individual or a device that is reasonably linkable to an individual or individuals that relates to any of these topics in any electronic format or media is considered electronic health information. Electronic health information does not include deidentified information.

3. "Health care services" means any past, present, or future medical treatment or other related services an individual may receive for a disability, physical health condition, or mental health condition.

4. "Process" or "processing" means an operation or set of operations performed on electronic health information, including but not limited to the collection, use, access, sharing, sale, monetization, analysis, retention, creation, generation, derivation, recording, organization, structuring, storage, disclosure, transmission, disposal, licensing, destruction, deletion, modification, or deidentification of electronic health information.

5. "Regulated entity" means any entity that controls the processing of electronic health information. A regulated entity may also be a service

provider depending upon the context in which electronic health information is processed.

6. "Sell" means to share electronic health information for monetary or other valuable consideration. Selling does not include the sharing of electronic health information for monetary or other valuable consideration to a third party as an asset that is part of a merger, acquisition, bankruptcy, or other transaction in which the third party assumes control of all or part of the regulated entity's assets.

7. "Service provider" means any person or entity that processes electronic health information on behalf of a regulated entity. A service provider may also be a regulated entity depending upon the context in which electronic health information is processed.

8. "Third party" means a person or entity other than the individual, regulated entity, or service provider involved in a transaction or occurrence that involves electronic health information. A third party may also be a regulated entity or service provider depending upon the context in which electronic health information is processed.

9. "Written consent" means a signed document that unambiguously communicates an individual's voluntary, opt-in authorization for processing of electronic health information. The document must be signed by the individual who is the subject of the electronic health information, or a parent or guardian authorized by law to take actions of legal consequence on behalf of the individual who is the subject of the electronic health information.

§ 1101. Requirements for communications to individuals. All notices, disclosures, and other communications to individuals provided pursuant to this article shall comply with the following:

1. All communications shall use plain, straightforward language, avoiding technical or legal jargon, and must be provided through an interface regularly used in conjunction with the regulated entity's product or service.

2. All communications shall be reasonably accessible to individuals with disabilities, including by:

(a) Utilizing digital accessibility tools;

(b) For notices, complying with generally recognized industry standards, including, but not limited to, the Web Content Accessibility Guidelines, version 2.1 of June 5, 2018, from the World Web Consortium, incorporated herein by reference; and

(c) For other communications, providing information about how an individual with a disability may access the communication in an alternative format.

3. All communications shall be available in the languages in which the regulated entity provides information via its website and services. Any direct communication to an individual shall be provided in the language in which the individual ordinarily interacts with the regulated entity or its service provider.

4. A regulated entity shall make any notice for processing pursuant to a permissible purpose, pursuant to subparagraph (ii) of paragraph (c) of subdivision one of section eleven hundred two of this article, or processing pursuant to written consent, pursuant to subparagraph (i) of paragraph (c) of subdivision one of section eleven hundred two of this article, publicly available on its website. If the notice for written consent is customized for each individual, the regulated entity may instead publicly post a sample notice on its website.

§ 1102. Lawfulness of processing electronic health information. 1. It shall be unlawful for a regulated entity to:

(a) Sell an individual's electronic health information to a third party.

(b) Process an individual's electronic health information to advertise or market products or services. This does not include (i) contextual advertising, meaning non-personalized advertising shown as part of an individual's current interaction with the regulated entity's services, provided that the individual's electronic health information is not disclosed to any third party and is not used to build a profile about the individual or otherwise alter the individual's experience outside the current interaction with the regulated entity's services; and (ii) reporting and analytics related to advertising effectiveness, such as statistical reporting, traffic analysis, and conversion measurement.

(c) Otherwise process an individual's electronic health information unless:

(i) The individual has provided written consent for such processing; or

(ii) Processing of an individual's electronic health information is strictly necessary for the purpose of:

(A) Providing a product or service requested by such individual;

(B) Conducting the regulated entity's internal business operations, which exclude any activities related to marketing, advertising, or providing products or services to third parties;

(C) Protecting against malicious, fraudulent, or illegal activity;

(D) Detecting, responding to, or preventing security incidents or threats;

(E) Protecting the vital interests of an individual or the public interest in the area of public health;

(F) Investigating, establishing, exercising, preparing for, or defending legal claims; or

(G) Complying with the regulated entity's legal obligations.

2. A regulated entity that processes electronic health information pursuant to subparagraph (i) of paragraph (c) of subdivision one of this section shall comply with the following:

(a) A request for written consent to process an individual's electronic health information shall:

(i) Be made separately from any other transaction or part of a transaction;

(ii) Be made in the absence of any mechanism in the user interface that has the purpose or substantial effect of obscuring, subverting, or impairing an individual's decision-making regarding consent for processing;

(iii) If requesting consent for multiple categories of processing activities, allow the individual to provide/withhold consent separately for each category of processing activity; and

(iv) Not include any request for consent for a processing activity for which an individual has withheld or revoked consent within the past calendar year.

(b) At the time of requesting written consent, the regulated entity shall provide the individual with a clear and conspicuous notice, separate from a privacy policy, terms of service, or similar document, that describes:

(i) the types of electronic health information to be processed;

(ii) the nature of the processing activity, such as, collection, analysis, etc.;

(iii) the specific purposes for such processing;

(iv) the names and/or categories of service providers and third parties to which the regulated entity may disclose the individual's electronic health information and the purposes for such disclosure, including the circumstances under which the regulated entity may disclose electronic health information to law enforcement;

(v) the voluntary nature of the consent;

(vi) the expiration date of the written consent, which may be up to one year from the date written consent was provided;

(vii) the mechanism by which the individual may revoke consent prior to expiration;

(viii) the mechanism by which the individual may request access to and deletion of their electronic health information; and

(ix) any other information material to an individual's decision-making regarding consent for processing.

(c) (i) A regulated entity that receives written consent for processing shall provide a cost-effective, timely, and easy-to-use mechanism by which an individual may revoke consent at any time through an interface regularly used in conjunction with the regulated entity's product or service.

(ii) Upon an individual's revocation of consent, the regulated entity shall immediately cease all processing activities for which consent was revoked, except to the extent necessary to comply with the regulated entity's legal obligations.

(iii) For individuals who have an online account with the regulated entity, the regulated entity must provide, in a conspicuous and easily accessible place within the account settings, a list of all processing activities for which the individual has provided written consent and, for each processing activity, allow the individual to revoke consent in the same place with one motion or action.

(d) Upon obtaining written consent from an individual, the regulated entity shall provide that individual an acknowledgement that states the type and purpose of processing to which the individual has consented, when the consent expires, and how to revoke consent prior to expiration. The acknowledgment shall also state how the individual may request access to and deletion of their electronic health information. The acknowledgement shall be provided in a manner that is capable of being retained by the individual.

(e) The regulated entity shall limit its processing to what was clearly disclosed to an individual pursuant to paragraph (b) of this subdivision when the regulated entity received written consent from the individual.

(f) If the regulated entity seeks to materially alter its processing activities for electronic health information collected pursuant to written consent, the regulated entity shall obtain a new written consent for the new or altered processing activity.

(g) Providing a product or service requested by an individual must not be made contingent on providing consent. The regulated entity must not discriminate against an individual for withholding consent, such as by charging different prices or rates for products or services, including through the use of discounts or other benefits, imposing penalties, or providing a different level or quality of services or goods to the individual.

3. A regulated entity that processes electronic health information pursuant to a permissible purpose pursuant to subparagraph (ii) of paragraph (c) of subdivision one of this section shall comply with the following:

(a) A regulated entity shall provide clear and conspicuous notice that describes:

(i) the types of electronic health information to be processed;

(ii) the nature of the processing activity, e.g., collection, analysis, etc.;

(iii) the specific purposes for such processing;

(iv) the names and/or categories of service providers and third parties to which the regulated entity may disclose the individual's electronic health information and the purposes for such disclosure, including the circumstances under which the regulated entity may disclose electronic health information to law enforcement; and

(v) the mechanism by which the individual may request access to and deletion of their electronic health information.

(b) The regulated entity shall limit its processing to what is reasonably necessary to fulfill the permissible purpose disclosed at the time of collection pursuant to paragraph (a) of this subdivision. A processing purpose is reasonably necessary to fulfill a permissible purpose when it is aligned with the reasonable expectations of an individual based on the individual's relationship with the organization and the context in which the individual provided the electronic health information.

(c) If the regulated entity materially alters its processing activities for electronic health information collected pursuant to a permissible purpose, the regulated entity must provide a clear and conspicuous notice in plain language, separate from a privacy policy, terms of service, or similar document, that describes any material changes to the processing activities and provides the individual with an opportunity to request deletion of their electronic health information.

§ 1103. Individual rights. 1. (a) A regulated entity shall make available a cost-effective, timely, and easy-to-use mechanism by which an individual may request access to their electronic health information.

(b) Within thirty days of receiving an access request, the regulated entity shall make available a copy of electronic health information about the individual.

2. (a) A regulated entity shall make available a cost-effective, timely, and easy-to-use mechanism by which an individual may request the deletion of their electronic health information.

(b) An individual's deletion or cancellation of their online account shall be treated as a request to delete the individual's electronic health information.

(c) Within thirty days of receiving a deletion request, the regulated entity shall:

(i) Delete all electronic health information associated with the individual in the regulated entity's possession or control, except to the extent necessary to comply with the regulated entity's legal obligations; and

(ii) Unless it proves impossible or involves disproportionate effort that is documented in writing by the regulated entity, communicate such request to each service provider or third party that processed the individual's electronic health information in connection with a transaction involving the regulated entity within one year preceding the individual's request and require those service providers or third parties to do the same for any further service providers or third parties that processed the individual's health information.

3. Any right set forth in this section may be exercised at any time by:

(a) The individual who is the subject of the electronic health information;

(b) A parent or guardian authorized by law to take actions of legal consequence on behalf of the individual who is the subject of the electronic health information; or

(c) An agent authorized by the individual who is the subject of the electronic health information.

§ 1104. Security. 1. A regulated entity shall develop, implement, and maintain reasonable administrative, technical, and physical safeguards to protect the security, confidentiality, and integrity of electronic health information.

2. A regulated entity must securely dispose of an individual's electronic health information pursuant to a publicly available retention schedule within a reasonable time, and in no event later than sixty days, after it is no longer necessary to fulfill the permissible purpose identified in the notice or for which the individual provided written consent.

§ 1105. Service providers. 1. Any processing of electronic health information data by a service provider on behalf of a regulated entity shall be governed by a written, binding agreement. Such agreement shall clearly set forth instructions for processing electronic health information, the nature and purpose of processing, the duration of processing, and the rights and obligations of both parties.

2. An agreement pursuant to subdivision one of this section shall require that the service provider:

(a) Ensure that each person processing electronic health information is subject to a duty of confidentiality with respect to such information;

(b) Protect electronic health information in a manner consistent with the requirements of this article;

(c) Process electronic health information only when and to the extent necessary to comply with its obligations to the regulated entity unless otherwise explicitly authorized by the regulated entity;

(d) Not combine the electronic health information which the service provider receives from or on behalf of the regulated entity with any other personal information which the service provider receives from or on behalf of another party or collects from its own relationship with individuals;

(e) Comply with any exercises of an individual's rights under section eleven hundred three of this article upon the request of the regulated entity;

(f) At the regulated entity's direction, delete or return all electronic health information to the regulated entity as requested at the end of the provision of services, unless retention of the electronic health information is required by law;

(g) Upon the reasonable request of the regulated entity, make available to the regulated entity all data in its possession necessary to demonstrate the service provider's compliance with the obligations in this section;

(h) Allow, and cooperate with, reasonable assessments by the regulated entity or the regulated entity's designated assessor for purposes of evaluating compliance with the obligations of this article; alternatively, the service provider may arrange for a qualified and independent assessor to conduct an assessment of the processor's policies and technical and organizational measures in support of the obligations under this article using an appropriate and accepted control standard or

framework and assessment procedure for such assessments. The service provider shall provide a report of such assessment to the regulated entity upon request;

(i) A reasonable time in advance before disclosing or transferring electronic health information to any further service providers, notify the regulated entity of such a proposed disclosure or transfer, which may be in the form of a regularly updated list of further service providers that may access electronic health information; and

(j) Engage any further service provider pursuant to a written, binding agreement that includes the contractual requirements provided in this section, containing at minimum the same obligations that the service provider has entered into with regard to electronic health information.

§ 1106. Exemptions. Nothing in this article shall apply to:

1. Information processed by local, state, and federal governments, and municipal corporations;

2. Protected health information that is collected by a covered entity or business associate governed by the privacy, security, and breach notification rules issued by the United States Department of Health and Human Services, Parts 160 and 164 of Title 45 of the Code of Federal Regulations, established pursuant to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the Health Information Technology for Economic and Clinical Health Act (Public Law 111-5);

3. Any covered entity governed by the privacy, security, and breach notification rules issued by the United States Department of Health and Human Services, Parts 160 and 164 of Title 45 of the Code of Federal Regulations, established pursuant to the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), to the extent the covered entity maintains patient information in the same manner as protected health information as described in subdivision two of this section;

4. Information collected as part of a clinical trial subject to the Federal Policy for the Protection of Human Subjects, also known as the Common Rule, pursuant to good clinical practice guidelines issued by the International Council for Harmonisation or pursuant to human subject protection requirements of the United States Food and Drug Administration;

5. Information processed pursuant to the federal Family Educational Rights and Privacy Act (20 U.S.C. Sec. 1232g) and its implementing regulations;

6. Information processed pursuant to section two-d of the education law; and

7. Information processed pursuant to the federal Driver's Privacy Protection Act of 1994 (18 U.S.C. Sec. 2721 et seq).

§ 1107. Enforcement. 1. Whenever it appears to the attorney general, either upon complaint or otherwise, that any person or persons, within or outside the state, has engaged in or is about to engage in any of the acts or practices stated to be unlawful under this article, the attorney general may bring an action or special proceeding in the name and on behalf of the people of the state of New York to enjoin any violation of this article, to obtain restitution of any moneys or property obtained directly or indirectly by any such violation, to obtain disgorgement of any profits obtained directly or indirectly by any such violation, to obtain civil penalties of not more than fifteen thousand dollars per violation, and to obtain any such other and further relief as the court may deem proper, including preliminary relief.

2. The remedies provided by this section shall be in addition to any other lawful remedy available.

3. Any action or special proceeding brought by the attorney general pursuant to this section must be commenced within six years of the date on which the attorney general became aware of the violation.

4. In connection with any proposed action or special proceeding under this section, the attorney general is authorized to take proof and make a determination of the relevant facts, and to issue subpoenas in accordance with the civil practice law and rules. The attorney general may also require such other data and information as he or she may deem relevant and may require written responses to questions under oath. Such power of subpoena and examination shall not abate or terminate by reason of any action or special proceeding brought by the attorney general under this article.

5. This section shall apply to all acts declared to be unlawful in this article, whether or not subject to any other law of this state, and shall not supersede, amend or repeal any other law of this state under which the attorney general is authorized to take any action or conduct any inquiry.

6. Any individual who has been injured by a violation of this article may bring an action in their own name in any court of competent jurisdiction to enjoin such unlawful act or practice and to recover their actual damages or one thousand dollars per individual, whichever is greater. The court may also award reasonable attorney's fees to a prevailing plaintiff. Actions pursuant to this section may be brought on a class-wide basis.

§ 2. Severability. 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 one year after it shall have become a law.

PART V

Intentionally Omitted

PART W

Intentionally Omitted

PART X

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

ARTICLE 29-K
REGISTRATION OF TEMPORARY HEALTH CARE SERVICES AGENCIES

Section 2999-ii. Definitions.

2999-jj. Registration of temporary health care services agencies; requirements.
2999-kk. Temporary health care services agencies; minimum standards.
2999-ll. Violations; penalties.
2999-mm. Rates for temporary health care services; reports.

§ 2999-ii. Definitions. For the purposes of this article:

1. "Certified nurse aide" means a person included in the nursing home nurse aide registry pursuant to section twenty-eight hundred three-j of this chapter as added by chapter seven hundred seventeen of the laws of nineteen hundred eighty-nine.

2. "Controlling person" means a person, officer, program administrator, or director whose responsibilities include the direction of the management or policies of a temporary health care services agency. "Controlling person" also means an individual who, directly owns at least ten percent voting interest in a corporation, partnership, or other business entity that is a controlling person.

3. "Health care entity" means an agency, corporation, facility, or individual providing medical or health care services.

4. "Health care personnel" means nurses, certified nurse aides and licensed or unlicensed direct care workers employed by the temporary health care services agency to provide temporary services in a health care entity.

5. "Nurse" means a registered professional nurse, or a licensed practical nurse as defined by article one hundred thirty-nine of the education law.

6. "Direct care worker" means an employee who is responsible for patient/resident handling or patient/resident assessment as a regular or incidental part of their employment, including any licensed or unlicensed health care worker.

7. "Person" means an individual, firm, corporation, partnership, or association.

8. "Temporary health care services agency" or "agency" means a person, firm, corporation, partnership, association or other entity in the business of providing or procuring temporary employment of health care personnel for health care entities. Temporary health care services agency shall include a nurses' registry licensed under article eleven of the general business law and entities that utilize apps or other technology-based solutions to provide or procure temporary employment of health care personnel in health care entities. Temporary health care services agency shall not include: (a) an individual who only engages in providing the individual's own services on a temporary basis to health care entities; or (b) a home care agency licensed under article thirty-six of this chapter.

§ 2999-jj. Registration of temporary health care services agencies; requirements. 1. Any person who operates a temporary health care services agency shall register the agency with the department. Each separate location of the business of a temporary health care services agency shall have a separate registration.

2. The commissioner shall publish guidelines establishing the forms and procedures for applications for registration. Forms must include, at a minimum all of the following:

(a) The names and addresses of the temporary health care services agency controlling person or persons.

(b) The names and addresses of health care entities where the controlling person or persons or their family members:

(i) have an ownership relationship; or

(ii) direct the management or policies of such health care entities.

(c) A demonstration that the applicant is of good moral character and able to comply with all applicable state laws and regulations relating to the activities in which it intends to engage under the registration.

(d) Registration and registration annual renewal fees of one thousand dollars and may only be used for the purpose of operating this registry.

(e) The state of incorporation of the agency.

(f) Any additional information that the commissioner determines is necessary to properly evaluate an application for registration.

3. As a condition of registration, a temporary health care services agency:

(a) Shall document that each temporary employee provided to health care entities currently meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working.

(b) Shall comply with all pertinent requirements and qualifications for personnel employed in health care entities.

(c) Shall not restrict in any manner the employment opportunities of its employees.

(d) Shall maintain insurance coverage for workers' compensation and disability coverage for all health care personnel provided or procured by the agency.

(e) Shall not require the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of a health care entity in any contract with any employee or health care entity or otherwise.

(f) Shall document that each temporary employee provided to health care entities is jointly employed by the agency and the entity and is not an independent contractor.

(g) Shall retain all records of employment for six calendar years and make them available to the department upon request.

(h) Shall comply with any requests made by the department to examine the books and records of the agency, subpoena witnesses and documents and make such other investigation as is necessary in the event that the department has reason to believe that the books or records do not accurately reflect the financial condition or financial transactions of the agency.

(i) Shall comply with any additional requirements the department may deem necessary.

4. A registration issued by the commissioner according to this section shall be effective for a period of one year, unless the registration is revoked or suspended, or unless ownership interest of ten percent or more, or management of the temporary health care services agency, is sold or transferred. When ownership interest of ten percent or more, or management of a temporary health care services agency is sold or transferred, the registration of the agency may be transferred to the new owner or operator for thirty days, or until the new owner or operator applies and is granted or denied a new registration, whichever is sooner.

5. The commissioner may, after appropriate notice and hearing, suspend, revoke, or refuse to issue or renew any registration or issue any fines established pursuant to section twenty-nine hundred ninety-nine-ll of this article if the applicant fails to comply with this article or any guidelines, rules and regulations promulgated thereunder.

6. The commissioner shall make available a list of temporary health care services agencies registered with the department on the department's public website.

7. The department shall publish a quarterly report containing aggregated and de-identified data collected pursuant to this article on the website of the department.

8. The department, in consultation with the department of labor, shall provide a report to the governor and legislature on or before March thirty-first, two thousand twenty-four, summarizing the key findings of the data collected pursuant to this article. The department shall further have authority to utilize any data collected pursuant to this article for additional purposes consistent with this chapter, including but not limited to determinations of whether an acute labor shortage exists, or any other purpose the department deems necessary for health care related data purposes.

9. The attorney general shall, upon the request of the department, bring an action for an injunction against any person who violates any provision of this article; provided, the department shall furnish the attorney general with such material, evidentiary matter or proof as may be requested by the attorney general for the prosecution of such action.

§ 2999-kk. Temporary health care services agencies; minimum standards. 1. A temporary health care services agency shall appoint an administrator qualified by training, experience or education to operate the agency. Each separate agency location shall have its own administrator.

2. A temporary health care services agency shall develop and maintain written employment policies and procedures. The agency shall inform its employees of the terms and conditions of employment by that agency at the time of hire, as well as no less than annually thereafter.

3. A temporary health care services agency shall maintain hours of operation at each of its locations sufficient to meet the obligations under its written agreements with health care entities.

4. A temporary health care services agency shall maintain a written agreement or contract with each health care entity, which shall include, at a minimum:

(a) The required minimum licensing, training, and continuing education requirements for each assigned health care personnel.

(b) Any requirement for minimum advance notice in order to ensure prompt arrival of assigned health care personnel.

(c) The maximum rates that can be billed or charged by the temporary health care services agency pursuant to section twenty-nine hundred ninety-nine-mm of this article and any applicable regulations.

(d) The rates to be charged by the temporary health care services agency.

(e) Procedures for the investigation and resolution of complaints about the performance of temporary health care services agency personnel.

(f) Procedures for notice from health care entities of failure of medical personnel to report to assignments and for back-up staff in such instances.

(g) Procedures for notice of actual or suspected abuse, theft, tampering or other diversion of controlled substances by medical personnel.

(h) The types and qualifications of health care personnel available for assignment through the temporary health care services agency.

5. A temporary health care services agency shall submit to the department copies of all contracts between the agency and a health care entity to which it assigns or refers health care personnel, and copies of all

invoices to health care entities personnel. Executed contracts must be sent to the department within five business days of their effective date and are not subject to disclosure under article six of the public officers law.

6. The commissioner may promulgate regulations to implement the requirements of this section and to establish additional minimum standards for the operation of temporary health care services agencies, including but not limited to pricing, fees, administrative costs, and business practices.

7. The commissioner may waive the requirements of this article during a declared state or federal public health emergency.

§ 2999-ll. Violations; penalties. In addition to other remedies available by law, violations of the provisions of this article and any regulations promulgated thereunder shall be subject to penalties and fines pursuant to section twelve of this chapter; provided, however, that each violation committed by each individual employee of a temporary health care services agency shall be considered a separate violation.

§ 2999-mm. Rates for temporary health care services; reports. A temporary health care services agency shall report quarterly to the department a full disclosure of charges and compensation, including a schedule of all hourly bill rates per category of employee, a full description of administrative charges, and a schedule of rates of all compensation per category of employee, including, but not limited to:

1. hourly regular pay rate, shift differential, weekend differential, hazard pay, charge nurse add-on, overtime, holiday pay, travel or mileage pay, and any health or other fringe benefits provided;

2. the percentage of health care entity dollars that the agency expended on temporary personnel wages and benefits compared to the temporary health care services agency's profits and other administrative costs;

3. a list of the states and zip codes of their employees' primary residences;

4. the names of all health care entities they have contracted within New York state;

5. the number of employees of the temporary health care services agency working at each entity; and

6. any other information prescribed by the commissioner.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023.

PART Y

Section 1. This Part enacts into law major components of legislation relating to medical debt and drug prices. Each component is wholly contained within a Subpart identified as Subparts A through D. 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 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 Part sets forth the general effective date of this Part.

SUBPART A

Section 1. Subdivisions (f) and (j) of section 3215 of the civil practice law and rules, subdivision (f) as amended and subdivision (j) as added by chapter 593 of the laws of 2021, subdivision (f) as separately amended by chapter 831 of the laws of 2021, are amended to read as follows:

(f) Proof. On any application for judgment by default, the applicant shall file proof of service of the summons and the complaint, or a summons and notice served pursuant to subdivision (b) of rule 305 or subdivision (a) of rule 316 of this chapter, and proof of the facts constituting the claim, the default and the amount due, including, if applicable, a statement that the interest rate for consumer debt pursuant to section five thousand four of this chapter applies, by affidavit made by the party, or where the state of New York is the plaintiff, by affidavit made by an attorney from the office of the attorney general who has or obtains knowledge of such facts through review of state records or otherwise. Where a verified complaint has been served, it may be used as the affidavit of the facts constituting the claim and the amount due; in such case, an affidavit as to the default shall be made by the party or the party's attorney. In an action arising out of a consumer credit transaction, if the plaintiff is not the original creditor, the applicant shall include: (1) an affidavit by the original creditor of the facts constituting the debt, the default in payment, the sale or assignment of the debt, and the amount due at the time of sale or assignment; (2) for each subsequent assignment or sale of the debt to another entity, an affidavit of sale of the debt by the debt seller, completed by the seller or assignor; and (3) an affidavit of a witness of the plaintiff, which includes a chain of title of the debt, completed by the plaintiff or plaintiff's witness. **In an action arising from medical debt, if the plaintiff is not a hospital licensed under article twenty-eight of the public health law or a health care professional authorized under title eight of the education law, the applicant shall include: (1) an affidavit by the hospital or health care professional of the facts constituting the medical debt, the default in payment, the sale or assignment of the medical debt, and the amount due at the time of sale or assignment; (2) for each subsequent assignment or sale of the medical debt to another entity, an affidavit of sale of the medical debt by the debt seller, completed by the seller or assignor; and (3) an affidavit of a witness of the plaintiff, which includes a chain of title of the medical debt, completed by the plaintiff or plaintiff's witness.** The chief administrative judge shall issue form affidavits to satisfy the requirements of this subdivision for consumer credit transactions **and actions arising from medical debt**. When jurisdiction is based on an attachment of property, the affidavit must state that an order of attachment granted in the action has been levied on the property of the defendant, describe the property and state its value. Proof of mailing the notice required by subdivision (g) of this section, where applicable, shall also be filed.

(j) Affidavit. A request for a default judgment entered by the clerk, must be accompanied by an affidavit by the plaintiff or plaintiff's attorney stating that after reasonable inquiry, he or she has reason to believe that the statute of limitations has not expired. The chief administrative judge shall issue form affidavits to satisfy the requirements of this subdivision for consumer credit transactions **and actions arising from medical debt**.

§ 2. Subdivision 2 of section 212 of the judiciary law is amended by adding a new paragraph (cc) to read as follows:

(cc) Make available form affidavits required for a motion for default judgment in an action arising from medical debt as required by subdivision (f) of section thirty-two hundred fifteen of the civil practice law and rules.

§ 3. This act shall take effect on the one hundred eightieth day after it shall have become a law.

SUBPART B

Section 1. This act shall be known and may be cited as the "Prescription Drug Price and Supply Chain Transparency Act of 2023".

§ 2. Legislative intent. The state has a compelling interest in providing for transparency into the price of prescription drugs and the regulation of entities that play a role in the distribution of prescription drugs in this state. The impact of ever rising prescription drug costs impacts consumers in this state both at the pharmacy counter and in health plan premium costs. Prescription drug costs also have direct costs to the state fiscal, health insurance companies, pharmacies, pharmacy benefit managers, hospitals, employers, and unions.

§ 3. The insurance law is amended by adding a new article 30 to read as follows:

ARTICLE 30
PRESCRIPTION DRUG PRICE AND SUPPLY CHAIN TRANSPARENCY

Section 3001. Definitions.
3002. Filing requirement.
3003. Special reports and other powers.
3004. Reporting of drug price increases.
3005. Presumption against pay for delay agreements.
3006. Registration of pharmacy services administrative organizations.
3007. Required disclosures by pharmacy services administrative organizations.
3008. Registration of pharmacy switch companies.
3009. Required disclosures by pharmacy switch companies.
3010. Registration of rebate aggregators.
3011. Required disclosures by rebate aggregators.
3012. Deposit of penalties and fees.

§ 3001. Definitions. (a) For the purposes of this article, the definitions contained in section two hundred eighty-a of the public health law shall apply to this article as if specifically set forth herein.

(b) The following words or phrases, as used in this article, shall have the following meanings, unless the context otherwise requires:

(1) "Manufacturer" means an entity engaged in the manufacture of prescription drugs sold in this state.

(2) "Pharmacy services administrative organization" or "PSAO" means a entity that is operating in this state and that contracts with a pharmacy for the purpose of conducting business on the pharmacy's behalf with wholesalers, distributors, health plans or pharmacy benefit managers.

(3) "Rebate aggregator" means an entity that provides formulary rebate administrative services for pharmacy benefit managers or otherwise negotiates rebates with manufacturers on behalf of pharmacy benefit managers.

(4) "Switch company" means an entity that acts as an intermediary between a pharmacy and a pharmacy benefit manager or health plan for the purpose of routing insurance claims data to or from a pharmacy.

(5) "Wholesaler" means an entity that bottles, packs or purchases drugs, devices or cosmetics for the purpose of selling or reselling to pharmacies or to other channels.

(6) "ANDA" shall mean abbreviated new drug application as described by 505(j) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 335(j).

(7) "ANDA filer" shall mean a party that owns or controls an ANDA filed with the federal food and drug administration or has the exclusive rights under that ANDA to distribute the ANDA product.

(8) "Agreement" shall mean anything that would constitute an agreement under state law.

(9) "Agreement resolving or settling a patent infringement claim" includes any agreement that is entered into within thirty days of the resolution or the settlement of the claim, or any other agreement that is contingent upon, provides a contingent condition for, or is otherwise related to the resolution or settlement of the claim. This shall include, but is not limited to, the following:

(A) Any agreement required to be provided to the federal trade commission or the antitrust division of the United States Department of Justice under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173;

(B) Any agreement between a biosimilar or interchangeable product applicant and a reference product sponsor under the Biologics Price Competition and Innovation Act of 2009, Pub. L. No. 111-148, that resolves patent claims between the applicant and sponsor.

(10) "Biosimilar biological product application filer" shall mean a party that owns or controls a biosimilar biological product application filed with the federal food and drug administration pursuant to section 351(k) of the Public Health Service Act, 42 U.S.C. 262(k), for licensure of a biological product as biosimilar to, or interchangeable with, a reference product, or that has the exclusive rights under the application to distribute the biosimilar biological product.

(11) "NDA" shall mean a new drug application.

(12) "Nonreference drug filer" shall mean either:

(A) An ANDA filer;

(B) A company that seeks an abbreviated approval pathway for its drug product under 505(b)(2) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(b)(2); or

(C) A biosimilar biological product application filer, or company seeking FDA approval for a biosimilar under 42 U.S.C. 262.

(13) "Nonreference drug product" shall mean the product to be manufactured under an ANDA or an application filed under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(b), that is the subject of the patent infringement claim, a biosimilar biological product that is the product to be manufactured under the biosimilar biological product application that is the subject of the patent infringement claim, or both.

(14) "Patent infringement" shall mean infringement of any patent or of any filed patent application, extension, reissue, renewal, division, continuation, continuation in part, reexamination, patent term restoration, patents of addition, and extensions thereof.

(15) "Patent infringement claim" shall mean any allegation made to a nonreference drug filer, whether or not included in a complaint filed with a court of law, that its nonreference drug product or application

infringes any patent held by, or exclusively licensed to, the reference drug holder.

(16) "Reference drug holder" shall mean either:

(A) A brand holder that is any of the following:

(i) The holder of an approved NDA for a drug product application filed under section 505(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(b);

(ii) A person owning or controlling enforcement of the patent listed in the approved drug products with therapeutic equivalence evaluations in connection with the NDA; or

(iii) The predecessors, subsidiaries, divisions, groups, and affiliates controlled by, controlling, or under common control with, any of the entities described in clause (i) or (ii) of this subparagraph, with control to be presumed by direct or indirect share ownership of fifty percent or greater, as well as the licensees, licensors, successors, and assigns of each of those entities; or

(B) A biological product license holder, which shall mean any of the following:

(i) The holder of an approved biological product license application for a biological drug product under section 351(a) of the Public Health Service Act, 42 U.S.C. 262(a);

(ii) A person owning or controlling enforcement of any patents that claim the biological product that is the subject of the approved biological patent license application; or

(iii) The predecessors, subsidiaries, divisions, groups, and affiliates controlled by, controlling, or under common control with, any of the entities described in clause (i) or (ii) of this subparagraph, with control to be presumed by direct or indirect share ownership of fifty percent or greater, as well as the licensees, licensors, successors, and assigns of each of those entities.

(17) "Reference drug product" shall mean the product to be manufactured by the reference drug holder and includes both branded drugs of the NDA holder and the biologic drug product of the biologic product license applicant.

(18) "Statutory exclusivity" shall mean those prohibitions on the approval of drug applications under clauses (ii) through (iv) of section 505(c)(3)(E), section 527 or section 505A of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c)(3)(E), on the licensing of biological product applications under section 262(k)(7) of Title 42 of the United States Code or section 262(m)(2) or (3) of Title 42 of the United States Code.

§ 3002. Filing requirement. Notwithstanding any law to the contrary, any filing or submission required under this article shall be made electronically unless the entity required to make that filing or submission demonstrates undue hardship, impracticability or good cause as required by section three hundred sixteen of this chapter.

§ 3003. Special reports and other powers. (a) The superintendent may address to any entity required to register or report information under this article, or its officers, or any agent or employee thereof any inquiry in relation to its business or any matter connected therewith. Every individual or entity so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of the entity, or by such agent or employee of the entity as the superintendent shall designate, and affirmed by them as true under the penalties of perjury.

(b) In the event any individual or entity does not submit a good faith response to an inquiry from the superintendent pursuant to subsection (a) of this section within a time period specified by the superintendent of not less than fifteen business days, the superintendent is authorized to levy a civil penalty, after notice and hearing, against such person not to exceed one thousand dollars per day for each day beyond the date specified by the superintendent for response to the inquiry.

(c) In addition to all other powers granted by law, the superintendent is hereby empowered to order any person or entity required to register or report information under this article to cease and desist from violations of this article and following issuance of such an order may bring and maintain an action in any court of competent jurisdiction for an injunction or other appropriate relief to enjoin threatened or existing violations of this article or of the superintendent's orders or regulations, such action may specifically seek restitution on behalf of persons aggrieved by a violation of this article or orders or regulations of the superintendent.

(d) In addition to all other powers granted by law, whenever it shall appear to the superintendent, either upon complaint or otherwise, that in the course of its business within or from this state that any entity shall have employed, or employs, or is about to employ any business practice or shall have performed, or is performing, or is about to perform any act in violation of this article or orders or regulations of the superintendent, or the superintendent believes it to be in the public interest that an investigation be made, the superintendent may, in the superintendent's discretion, either require or permit such entity or any agent or employee thereof, to file with the department a statement in writing under oath or otherwise as to all the facts and circumstances concerning the subject matter that the superintendent believes is in the public interest to investigate, and for that purpose may prescribe forms upon which such statements shall be made. The superintendent may also require such other data and information as the superintendent may deem relevant and may make such special and independent investigations as the superintendent may deem necessary in connection with the matter. It shall be the duty of all public officers, their deputies, assistants, subordinates, clerks or employees and all other persons to render and furnish to the superintendent, when requested in connection with an investigation under this subsection, all information and assistance in their possession or within their power.

(e) Any entity who violates an order under subsection (c) or (d) of this section shall be subject to a civil penalty, after notice and a hearing, of not more than ten thousand dollars per act in violation, in addition to any other penalty provided by law.

(f) Any communications or documents sent or received in connection with an investigation under this article, and materials referring to such information in the possession of the superintendent shall be confidential and not subject to disclosure by the superintendent except where and as the superintendent determines that disclosure is in the public interest. This subsection shall not apply to information, documents and materials in the possession and under the control of an entity other than the superintendent.

§ 3004. Reporting of drug price increases. (a)(1) No manufacturer or wholesaler may charge any price for a drug based on an increase in wholesale acquisition cost, average wholesale price, or any other metric unless the manufacturer shall first report the price to the department.

(2) No entity may sell or distribute in this state any drug for which a report was required to be made under this subsection until such report is made.

(b) The report required by subsection (a) of this section shall be made in a form and manner prescribed by the superintendent, shall be made individually for each national drug code, and shall include the following:

(1) the name or names of the drug;

(2) the national drug code for the drug;

(3) the price of the drug prior to the increase;

(4) the price of the drug following the increase;

(5) the effective date of the increase;

(6) the date on which the decision was made to increase the price; and

(7) the reason and justification for the increase.

(c) Not later than May first, two thousand twenty-five, the department shall begin publishing reports received under this section on a publicly accessible online database, which is searchable at least by manufacturer name, drug name, and national drug code. Reports shall be posted not later than fifteen business days after they are received and shall remain on the database for not less than one hundred eighty days after the effective date of the increase or the first date the report is posted, whichever is later, provided, however, that the superintendent may delay the posting of a report if posting within fifteen business days of receipt is not feasible.

(d) Notwithstanding any law to the contrary, the information contained in paragraphs six and seven of subsection (b) of this section or any statement required under subsection (g) of this section, together with any communications, documents, and materials referring to such information in the possession of the superintendent, shall be confidential and not subject to disclosure by the superintendent, except where the superintendent determines that disclosure is in the public interest. This subsection shall not apply to information, documents and materials in the possession and under the control of an entity other than the superintendent.

(e) No report shall be considered validly filed unless accompanied by a filing fee in an amount set forth in this subsection.

(1) For any report involving an increase that will not take effect for one hundred twenty days or more and for which the effective date of the change is between the first of January and the thirty-first of January and:

(A) for which the increase will result in a change of less than ten percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be twenty-five dollars;

(B) for which the increase will result in a change of less than twenty-five percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be twenty-five dollars;

(C) for which the increase will result in a change of less than fifty percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be two hundred fifty dollars; or

(D) for which the increase will result in a change of fifty percent or greater per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be one thousand dollars.

(2) For any report involving an increase that will not take effect for one hundred twenty days or more and for which the effective date is outside of the month of January and:

(A) for which the increase will result in a change of less than ten percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be two thousand five hundred dollars;

(B) for which the increase will result in a change of less than twenty-five percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be five thousand dollars;

(C) for which the increase will result in a change of less than fifty percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be seven thousand five hundred dollars; or

(D) for which the increase will result in a change of fifty percent or greater per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be ten thousand dollars.

(3) For any report involving an increase that will take effect in less than one hundred twenty days and for which the effective date of the change is between the first of January and the thirty-first of January and:

(A) for which the increase will result in a change of less than ten percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be two thousand five hundred dollars;

(B) for which the increase will result in a change of less than twenty-five percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be five thousand dollars;

(C) for which the increase will result in a change of less than fifty percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be seven thousand five hundred dollars; or

(D) for which the increase will result in a change of fifty percent or greater per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be ten thousand dollars.

(4) For any report involving an increase that will take effect in less than one hundred twenty days and for which the effective date of the change is outside of the month of January and:

(A) for which the increase will result in a change of less than ten percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be twenty-five thousand dollars;

(B) for which the increase will result in a change of less than twenty-five percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be fifty thousand dollars;

(C) for which the increase will result in a change of less than fifty percent per unit over the price of the same drug three hundred sixty-five days before the effective date of the change, the fee shall be seventy-five thousand dollars; or

(D) for which the increase will result in a change of fifty percent or greater per unit over the price of the same drug three hundred sixty-

five days before the effective date of the change, the fee shall be one hundred thousand dollars.

(5) For any report made after the effective date of the change, the fee shall be one hundred thousand dollars plus ten thousand dollars for each day after the effective date before the report is made.

(f) After notice and a hearing, the superintendent may impose a civil penalty on any entity that violates subsection (a) of this section in an amount not to exceed one million dollars per violation. In considering the amount of any such civil penalty, the superintendent shall consider:

(1) the timing of the increase;

(2) the cost of the drug;

(3) the impact on consumers;

(4) whether such violation is a first offense; and

(5) remedial measures the entity has put in place to prevent future violations.

(g) Whenever a report is made involving an increase that will take effect in less than one hundred twenty days, the manufacturer of the drug shall provide to the superintendent a statement of the reason that the increase must take effect in less than one hundred twenty days. When the superintendent believes it is in the public interest that an investigation be made, the superintendent may make independent and special investigations into the matter as the superintendent deems appropriate.

§ 3005. Presumption against pay for delay agreements. (a) (1) Except as provided in paragraph three of this subsection, an agreement resolving or settling, on a final or interim basis, a patent infringement claim, in connection with the sale of a pharmaceutical product, shall be presumed to have anticompetitive effects and shall be a violation of this section if both of the following apply:

(A) A nonreference drug filer receives anything of value from another company asserting patent infringement, including, but not limited to, an exclusive license or a promise that the brand company will not launch an authorized generic version of its brand drug; and

(B) The nonreference drug filer agrees to limit or forego research, development, manufacturing, marketing, or sales of the nonreference drug filer's product for any period of time.

(2) As used in subparagraph (A) of paragraph one of this subsection, "anything of value" shall be interpreted broadly to include any type of consideration, value or benefit a reference drug holder or nonreference drug filer could possibly obtain from the agreement. "Anything of value" shall not include a settlement of patent infringement claims in which the consideration granted by the reference drug holder to the nonreference drug filer as part of the resolution or settlement consists of only one or more of the following:

(A) The right to market the competing product in the United States before the expiration of either:

(i) A patent that is the basis for the patent infringement claim; or

(ii) A patent right or other statutory exclusivity that would prevent the marketing of the drug;

(B) A covenant not to sue on a claim that the nonreference drug product infringes a United States patent;

(C) Compensation for saved reasonable future litigation expenses of the reference drug holder but only if both of the following are true:

(i) The total compensation for saved litigation expenses is reflected in budgets that the reference drug holder documented and adopted at least six months before the settlement; and

(ii) The compensation shall not exceed the lower of the following:

(I) Seven million five hundred thousand dollars; or

(II) Five percent of the revenue that the nonreference drug filer projected or forecasted it would receive in the first three years of sales of its version of the reference drug documented at least twelve months before the settlement. If no projections or forecasts are available, the compensation shall not exceed two hundred fifty thousand dollars;

(D) An agreement by the reference drug holder not to interfere with the nonreference drug filer's ability to secure and maintain regulatory approval to market the nonreference drug product or an agreement to facilitate the nonreference drug filer's ability to secure and maintain regulatory approval to market the nonreference drug product; or

(E) An agreement resolving a patent infringement claim in which the reference drug holder forgives the potential damages accrued by a nonreference drug filer for an at-risk launch of the nonreference drug product that is the subject of that claim.

(3) Parties to an agreement are not in violation of paragraph one of this subsection if they can demonstrate by clear and convincing evidence that either of the following are met:

(A) The value received by the nonreference drug filer described in subparagraph (A) of paragraph one of this subsection is a fair and reasonable compensation solely for other goods or services that the nonreference drug filer has promised to provide; or

(B) The agreement has directly generated procompetitive benefits and the procompetitive benefits of the agreement outweigh the anticompetitive effects of the agreement.

(b) In determining whether the parties to the agreement have met their burden under paragraph three of subsection (a) of this section, a court of competent jurisdiction shall not consider any of the following:

(1) That entry into the marketplace could not have occurred until the expiration of the relevant patent exclusivity or that the agreement's provision for entry of the nonreference drug product before the expiration of any patent exclusivity means that the agreement is procompetitive within the meaning of subparagraph (B) of paragraph three of subsection (a) of this section;

(2) That any patent is enforceable and infringed by the nonreference drug filer in the absence of a final adjudication binding on the filer of those issues;

(3) That the agreement caused no delay in entry of the nonreference drug filer's drug product because of the lack of Federal Food and Drug Administration (FDA) approval of that or of another nonreference drug product; or

(4) That the agreement caused no harm or delay due to the possibility that the nonreference drug filer's drug product might infringe some patent that has not been asserted against the nonreference drug filer or that is not subject to a final and binding adjudication on that filer as to the patent's scope, enforceability, and infringement.

(c) In determining whether the parties to the agreement have met their burden under paragraph three of subsection (a) of this section, a court of competent jurisdiction shall presume that the relevant product market is that market consisting of the reference drug of the company alleging patent infringement and the drug product of the nonreference drug filer accused of infringement and any other biological product that is licensed as biosimilar or is an AB-rated generic to the reference product.

(d) (1) This section shall not modify, impair, limit, or supersede the applicability of the antitrust laws of the state pursuant to article twenty-two of the general business law, unfair competition laws of the state pursuant to article twenty-two-A of the general business law or the availability of damages or remedies provided therein. This section shall not modify, impair, limit, or supersede the right of any drug company applicant to assert claims or counterclaims against any person, under the antitrust laws or other laws relating to unfair competition of the federal antitrust law or state law.

(2) If any provision of this subsection, an amendment made to this subsection, or the application of any provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this subsection, the amendments made to this subsection, and the application of the provisions of this subsection or amendments to any person or circumstance shall not be affected.

(e) (1) (A) Each person that violates or assists in the violation of this section shall forfeit and pay to the state a civil penalty sufficient to deter violations of this section, as follows:

(i) If the person who violated this section received any value due to that violation, an amount up to three times the value received by the party that is reasonably attributable to the violation of this section, or twenty million dollars, whichever is greater; or

(ii) If the violator has not received anything of value as described in this subparagraph, an amount up to three times the value given to other parties to the agreement reasonably attributable to the violation of this section, or twenty million dollars.

(iii) For purposes of this subsection, "reasonably attributable to the violation" shall be determined by the state's share of the market for the brand drug at issue in the agreement.

(B) Any penalty described in subparagraph (A) of this paragraph shall accrue only to the state and shall be recovered in a civil action brought by the attorney general in its own name, or by any of its attorneys designated by it for that purpose, against any party to an agreement that violates this section.

(2) Each party that violates or assists in the violation of this section shall be liable for any damages, penalties, costs, fees, injunctions, or other equitable or legal remedies, including, but not limited to, restitution and disgorgement, that may be just and reasonable. Such remedies shall include, but not be limited to, any remedy available under article twenty-two or twenty-two-A of the general business law and section sixty-three of the executive law.

(3) If the state is awarded penalties under subparagraph (A) of paragraph one of this subsection, it shall not recover penalties pursuant to another law identified in paragraph two of this subsection. This section shall not be construed to foreclose the state's ability to claim any equitable or legal remedy available in paragraph two of this subsection.

(4) An action to enforce a cause of action for a violation of this section shall be commenced within six years after the cause of action accrued.

§ 3006. Registration of pharmacy services administrative organizations. (a) No PSAO shall operate in this state after March thirty-first, two thousand twenty-four without first registering with the department.

(b) A PSAO seeking registration shall file, in a form and manner determined by the superintendent, information that includes at a minimum:

(1) the legal name of the entity;
(2) any trade or other names used by the entity;
(3) the organizational structure of the entity;
(4) the pharmacies located within this state with which the entity provides services;
(5) the persons who exercise control of the entity;
(6) a primary point of contact for the entity;
(7) an agent for service of process;
(8) a set of audited financials for the prior fiscal year; and
(9) such other information as the superintendent shall require.

(c) The superintendent shall accept a registration only if the superintendent determines that all the required information has been provided in a satisfactory form and has received payment of a nonrefundable registration fee of five thousand dollars.

(d) If any of the information contained in the registration shall change, the PSAO shall notify the department of the change in a form and manner prescribed by the superintendent for such purpose within twenty-one days of the change. The requirement to update shall include the filing of a new set of audited financials upon adoption. For any change other than new audited financials, the filing shall not be deemed complete unless accompanied by a payment of a fee of fifty dollars.

(e) Every PSAO registration issued pursuant to this section shall expire twelve months after the date of issue. A PSAO may renew its registration for another twelve months upon the filing of an application in conformity with this section.

(f) Before a PSAO registration shall be renewed, the PSAO shall file an application for renewal in such form as the superintendent prescribes, and pay a fee of five thousand dollars.

(g) If a PSAO files a renewal application with the superintendent at least one month before its expiration, then the registration sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal registration applied for or until five days after the superintendent shall have refused to issue such renewal registration and given notice of such refusal to the applicant, otherwise the PSAO registration shall expire and the registrant shall have no expectation of renewal.

§ 3007. Required disclosures by pharmacy services administrative organizations. (a) (1) Each PSAO shall at the time of registration pursuant to section three thousand six of this article disclose to the department the extent of any ownership or control of the PSAO or by the PSAO of any parent company, subsidiary, or affiliate that:

(A) provides pharmacy services;
(B) provides prescription drug or device services; or
(C) manufactures, sells, or distributes prescription drugs, biologicals, or medical devices.

(2) A PSAO shall furnish a copy of the disclosure made at the time of registration to all pharmacies located in this state with which it has contract in place at the time of the registration. A PSAO shall not collect any fee for any services provided to a pharmacy for any period beginning five days after the filing of a registration with the department until the disclosure is sent to the pharmacy.

(3) Not later than April first, two thousand twenty-five, the department shall publish all disclosures received under this subsection on a publicly accessible online database, which is searchable at least by PSAO name. All disclosures shall be posted not later than ten business

days after a registration is accepted and shall remain on the database for the duration of the registration of the PSAO.

(b) (1) Prior to entering into any contract with any pharmacy located in this state, including a contract with a group of pharmacies at least one of which is in this state, a PSAO shall furnish to the pharmacy a written disclosure of the information required to be disclosed in subsection (a) of this section. No contract with a pharmacy shall be enforceable against the pharmacy by a PSAO unless that PSAO makes this disclosure prior to the agreement. In addition to any other power conferred by law, the superintendent may prescribe the form and manner of such disclosures.

(2) A PSAO that owns, is owned by, in whole or in part, or controls any entity that manufactures, sells, or distributes prescription drugs, biologicals, or medical devices shall not, as a condition of entering into a contract with a pharmacy, require that the pharmacy purchase any drugs or medical devices from an entity with which the PSAO has a financial interest, or an entity with an ownership interest in the PSAO.

(3) No PSAO shall enter into a contract with a pharmacy in this state unless that contract shall provide that all remittances for claims submitted by a pharmacy benefit manager or third-party payer on behalf of a pharmacy to the PSAO shall be passed through by the PSAO to the pharmacy within a reasonable amount of time, established in the contract, after receipt of the remittance by the PSAO from the pharmacy benefit manager or third-party payer.

(c) (1) A PSAO that provides, accepts, or processes a discount, concession, or product voucher, to reduce, directly or indirectly, a covered individual's out-of-pocket expense for the order, dispensing, substitution, sale, or purchase of a prescription drug shall make available to each pharmacy in this state that it contracts with or which it contracted with in the prior calendar year, an annual report that includes:

(A) an aggregated total of all such transactions, by the pharmacy; and

(B) an aggregated total of any payments received by the PSAO itself for providing, processing, or accepting any discount, concession, or product voucher on behalf of a pharmacy.

(2) A pharmacy in this state that is a party to a contract with a PSAO shall have a right to an accounting of the funds received by the PSAO for goods or services provided by the pharmacy to patients and customers.

§ 3008. Registration of pharmacy switch companies. (a) No switch company may do business in this state after June thirtieth, two thousand twenty-four without first registering with the department.

(b) A switch company seeking registration shall file with the department, in a form and manner determined by the superintendent, information including but not limited to:

(1) the legal name of the entity;

(2) any trade or other names used by the entity;

(3) the organizational structure of the entity;

(4) the pharmacies located within this state and the pharmacy benefit managers licensed in this state with which the entity provides services;

(5) the persons who exercise control of the entity;

(6) a primary point of contact for the entity;

(7) an agent for service of process;

(8) a set of audited financials for the prior fiscal year; and

(9) such other information or documents as the superintendent shall require.

(c) The superintendent shall accept a registration only if he or she deems that all the required information has been provided in a satisfactory form and has received payment of a nonrefundable registration fee of one thousand dollars.

(d) If any of the information contained in the registration shall change, the switch company shall notify the department of the change in a form and manner prescribed by the superintendent for such purpose within twenty-one days of the change. The requirement to update shall include the filing of a new set of audited financials upon adoption. For any change other than new audited financials, the filing shall not be deemed complete unless accompanied by a payment of a fee of fifty dollars.

(e) Every pharmacy switch company's registration shall expire twelve months after the date of issue. Every registration issued pursuant to this section may be renewed for the ensuing period of twelve months upon the filing of an application in conformity with this subsection.

(f) Before a pharmacy switch company's registration shall be renewed, the pharmacy switch company shall properly file in the office of the superintendent an application for renewal in such form as the superintendent prescribes, and pay a fee of one thousand dollars.

(g) If an application for a renewal registration shall have been filed with the superintendent at least one month before its expiration, then the registration sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal registration applied for or until five days after the superintendent shall have refused to issue such renewal registration and given notice of such refusal to the applicant, otherwise the registration shall expire and the registrant shall have no expectation of renewal.

§ 3009. Required disclosures by pharmacy switch companies. (a) Each switch company shall annually disclose to the department, in a form and manner prescribed by the superintendent, such information as the superintendent deems necessary for the proper supervision of the industry. Such information shall include:

(1) a list of services the switch company provides and the industries to which they are provided;

(2) information on electronic voucher services provided by the switch company, including:

(A) a list of manufacturers that the switch company has contracts with or for which it transmits electronic vouchers;

(B) a list of medications and the National Drug Codes (NDCs) for which the switch company may apply electronic vouchers; and

(C) the total amount of money collected from manufacturers related to transmission of electronic vouchers; and

(3) the number of transactions processed in this state and the total amount of revenue attributable to those transactions.

(b) A switch company shall disclose to each pharmacy benefit manager with which it does business any instance in which an electronic voucher was applied in the course of routing the claim.

§ 3010. Registration of rebate aggregators. (a) No rebate aggregator may do business in this state after September thirtieth, two thousand twenty-four without first registering with the department.

(b) A rebate aggregator seeking registration shall file, in a form and manner determined by the superintendent, information including but not limited to:

(1) the legal name of the entity;

(2) any trade or other names used by the entity;

(3) the organizational structure of the entity;

(4) the health plans and the pharmacy benefit managers licensed in this state for which the entity provides services;

(5) the persons who exercise control of the entity;

(6) a primary point of contact for the entity;

(7) an agent for service of process;

(8) a set of audited financials for the prior fiscal year; and

(9) such other information or documents as the superintendent shall require.

(c) The superintendent shall accept a registration only if he or she deems that all the required information has been provided in a satisfactory form and has received payment of a nonrefundable registration fee of one thousand dollars.

(d) If any of the information contained in the registration shall change the rebate aggregator shall notify the department of the change in a form and manner prescribed by the superintendent for such purpose within twenty-one days of the change. The requirement to update shall include the filing of a new set of audited financials upon adoption. For any change other than new audited financials, the filing shall not be deemed complete unless accompanied by a payment of a fee of fifty dollars.

(e) Every rebate aggregator's registration shall expire twelve months after the date of issue. Every registration issued pursuant to this section may be renewed for the ensuing period of twelve months upon the filing of an application in conformity with this subsection.

(f) Before a rebate aggregator's registration shall be renewed, the rebate aggregator shall properly file in the office of the superintendent an application for renewal in such form as the superintendent prescribes, and pay a fee of one thousand dollars.

(g) If an application for a renewal registration shall have been filed with the superintendent at least one month before its expiration, then the registration sought to be renewed shall continue in full force and effect either until the issuance by the superintendent of the renewal registration applied for or until five days after the superintendent shall have refused to issue such renewal registration and given notice of such refusal to the applicant, otherwise the registration shall expire and the registrant shall have no expectation of renewal.

§ 3011. Required disclosures by rebate aggregators. (a) Each rebate aggregator that has a contract or arrangement with a pharmacy benefit manager serving a health plan shall, on an annual basis, disclose in writing to the health plan the following:

(1) fee structure provisions of any contract or arrangement between the rebate aggregator and pharmacy benefit manager or drug manufacturer, including:

(A) fees collected for aggregating rebates due to the health plan; and

(B) such other information as the superintendent may require by regulation; and

(2) quantification of inflationary payments, credits, grants, reimbursements, other financial or other reimbursements, incentives, inducements, refunds or other benefits received by the rebate aggregator from the drug manufacturer and retained by the rebate aggregator, whether referred to as a rebate, a discount, or otherwise.

(b) (1) Each rebate aggregator shall, at the time of registration, disclose to the department the extent of any ownership or control of the rebate aggregator or by the rebate aggregator of any parent company,

subsidiary, or other affiliated organizations that provides pharmacy benefit management services.

(2) Each rebate aggregator shall on an annual basis disclose to the department the information requested by the superintendent, including:

(A) any payments made to a rebate aggregator by a drug manufacturer relating to a drug's utilization, including inflationary payments, credits, grants, reimbursements, other financial or other reimbursements, incentives, inducements, refunds or other benefits received by the rebate aggregator, whether referred to as a rebate, a discount, or otherwise;

(B) any payments made, including those described in subparagraph (A) of this paragraph and subsequently retained by a rebate aggregator;

(C) any fees charged by the rebate aggregator to the pharmacy benefit manager or drug manufacturer relating to a drug's utilization;

(D) any payments made to a rebate aggregator from a program administered by a drug manufacturer for the purpose of assisting patients with the cost of prescription drugs, including copayment assistance programs, discount cards, and coupons; and

(E) the terms and conditions of any contract or arrangement between the rebate aggregator and a pharmacy benefit manager or drug manufacturer.

§ 3012. Deposit of penalties and fees. Penalties and fees collected pursuant to this article shall be deposited into the pharmacy benefit manager regulatory fund established pursuant to section ninety-nine-oo of the state finance law.

§ 4. Subdivision 3 of section 99-oo of the state finance law, as added by chapter 128 of the laws of 2022, is amended to read as follows:

3. Such fund shall consist of money received by the state as fees under [~~article~~] articles twenty-nine and thirty of the insurance law or penalties ordered under [~~article~~] articles twenty-nine and thirty of the insurance law and all other monies appropriated, credited, or transferred thereto from any other fund or source pursuant to law. All monies shall remain in such fund unless and until directed by statute or appropriation.

§ 5. This act shall take effect on the one hundred fiftieth day after it shall have become a law.

SUBPART C

Section 1. Subdivision 9 of section 2807-k of the public health law, as amended by section 17 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must implement minimum collection policies and procedures approved by the commissioner, utilizing only a uniform financial assistance form developed and provided by the department.

§ 2. This act shall take effect April 1, 2024.

SUBPART D

Section 1. Legislative findings. The legislature finds that it is in the best interest of the people of this state to expand article 77 of the insurance law to protect insureds and health care providers against the failure or inability of a health or property/casualty insurer writing health insurance to perform its contractual obligations due to

financial impairment or insolvency. The superintendent of financial services has the right and responsibility to enforce the insurance law and the authority to seek redress against any person responsible for the impairment or insolvency of the insurer, and nothing in this act is intended to restrict or limit such right, responsibility, or authority.

§ 2. The article heading of article 77 of the insurance law, as added by chapter 802 of the laws of 1985, is amended to read as follows:

THE LIFE **AND HEALTH** INSURANCE COMPANY
GUARANTY CORPORATION
OF NEW YORK ACT

§ 3. Section 7701 of the insurance law, as added by chapter 802 of the laws of 1985, is amended to read as follows:

§ 7701. Short title. This article shall be known and may be cited as "The Life **and Health** Insurance Company Guaranty Corporation of New York Act".

§ 4. Section 7702 of the insurance law, as amended by chapter 454 of the laws of 2014, is amended to read as follows:

§ 7702. Purpose. The purpose of this article is to provide funds to protect policy owners, insureds, **health care providers,** beneficiaries, annuitants, payees and assignees of life insurance policies, health insurance policies, annuity contracts, funding agreements and supplemental contracts issued by life insurance companies, **health insurance companies, and property/casualty insurance companies,** subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the insurer issuing such policies, contracts, or funding agreements. In the judgment of the legislature, the foregoing objects and purposes not being capable of accomplishment by a corporation created under general laws, the creation of a not-for-profit corporation of insurers is provided for by this article to enable the guarantee of payment of benefits and of continuation of coverages, and members of the corporation are subject to assessment to carry out the purposes of this article.

§ 5. Paragraphs 1 and 2 of subsection (a) of section 7703 of the insurance law, as added by chapter 454 of the laws of 2014, are amended to read as follows:

(1) This article shall apply to direct life insurance policies, health insurance policies, annuity contracts, funding agreements, and supplemental contracts issued by a life insurance company**, health insurance company, or property/casualty insurance company** licensed to transact life or health insurance or annuities in this state at the time the policy, contract, or funding agreement was issued or on the date of entry of a court order of liquidation or rehabilitation with respect to such a company that is an impaired or insolvent insurer, as the case may be.

(2) Except as otherwise provided in this section, this article shall apply to the policies, contracts, and funding agreements specified in paragraph one of this subsection with regard to a person who is:

(A) an owner or certificate holder under a policy, contract, or funding agreement and in each case who:

(i) is a resident **of this state**; or

(ii) is not a resident **of this state**, but only under all of the following conditions:

(I) **(aa)** the insurer that issued the policy, contract, or agreement is domiciled in this state; **or**

(bb) the insurer that issued the policy, contract, or agreement is domiciled outside this state and the insurer delivered or issued for

delivery the policy, contract, or agreement in this state; provided, however, that for the purpose of this subitem, any certificate issued to an individual under any group or blanket policy or contract delivered or issued for delivery in this state shall be considered to have been delivered or issued for delivery in this state;

(II) the state or states in which the person resides has or have a guaranty entity similar to the corporation created by this article; and

(III) the person is not eligible for coverage by a guaranty entity in any other state because the insurer was not licensed or authorized in that state at the time specified in that state's guaranty entity law; [~~or~~]

(B) the beneficiary, assignee, or payee of the person specified in subparagraph (A) of this paragraph, regardless of where the person resides; or

(C) a health care provider that has rendered services to a person specified in subparagraph (A) of this paragraph.

§ 6. Subsections (c), (d), (e), (h), and (i) of section 7705 of the insurance law, subsections (c), (e) and (i) as added by chapter 802 of the laws of 1985 and subsections (d) and (h) as amended by chapter 454 of the laws of 2014, are amended and a new subsection (m) is added to read as follows:

(c) "Corporation" means The Life and Health Insurance Company Guaranty Corporation of New York created under section seven thousand seven hundred six of this article unless the context otherwise requires.

(d) "Covered policy" means any of the kinds of insurance specified in paragraph one, two or three of subsection (a) of section one thousand one hundred thirteen of this chapter, any supplemental contract, or any funding agreement referred to in section three thousand two hundred twenty-two of this chapter, or any portion or part thereof, within the scope of this article under section seven thousand seven hundred three of this article, except that any certificate issued to an individual under any group or blanket policy or contract shall be considered to be a separate covered policy for purposes of section seven thousand seven hundred eight of this article.

(e) "Health insurance" means the kinds of insurance specified under items (i) and (ii) of paragraph three and paragraph thirty-one of subsection (a) of section one thousand one hundred thirteen of this chapter, and section one thousand one hundred seventeen of this chapter; medical expense indemnity, dental expense indemnity, hospital service, or health service under article forty-three of this chapter; and comprehensive health services under article forty-four of the public health law. "Health insurance" shall not include hospital, medical, surgical, prescription drug, or other health care benefits pursuant to: (1) part C of title XVIII of the social security act (42 U.S.C. § 1395w-21 et seq.) or part D of title XVIII of the social security act (42 U.S.C. § 1395w-101 et seq.), commonly known as Medicare parts C and D, or any regulations promulgated thereunder; (2) titles XIX and XXI of the social security act (42 U.S.C. § 1396 et seq.), commonly known as the Medicaid and child health insurance programs, or any regulations promulgated thereunder; or (3) the basic health program under section three hundred sixty-nine-gg of the social services law.

(h) (1) "Member insurer" means:

(A) any life insurance company licensed to transact in this state any kind of insurance to which this article applies under section seven thousand seven hundred three of this article; provided, however, that the term "member insurer" also means any life insurance company formerly

licensed to transact in this state any kind of insurance to which this article applies under section seven thousand seven hundred three of this article; and

(B) an insurer licensed or formerly licensed to write accident and health insurance or salary protection insurance in this state, corporation organized pursuant to article forty-three of this chapter, reciprocal insurer organized pursuant to article sixty-one of this chapter, cooperative property/casualty insurance company operating under or subject to article sixty-six of this chapter, nonprofit property/casualty insurance company organized pursuant to article sixty-seven of this chapter, and health maintenance organization certified pursuant to article forty-four of the public health law, which is not a member of, or participant in, the fund or corporation created pursuant to article seventy-five or seventy-seven of this chapter.

(2) "Member insurer" shall not include a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, an employee welfare fund registered under article forty-four of this chapter, a fraternal benefit society organized under article forty-five of this chapter, an institution of higher education with a certificate of authority under section one thousand one hundred twenty-four of this chapter, or a continuing care retirement community with a certificate of authority under article forty-six or forty-six-A of the public health law.

(i) "Premiums" means direct gross insurance premiums and annuity and funding agreement considerations received on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders or contract holders on such direct business, subject to such modifications as the superintendent may establish by regulation or order as necessary to facilitate the equitable administration of this article. Premiums do not include premiums and considerations on contracts between insurers and reinsurers. For the purposes of determining the assessment for an insurer under this article, the term "premiums", with respect to a group annuity contract (or portion of any such contract) that does not guarantee annuity benefits to any specific individual identified in the contract and with respect to any funding agreement issued to fund benefits under any employee benefit plan, means the lesser of one million dollars or the premium attributable to that portion of such group contract that does not guarantee benefits to any specific individuals or such agreements that fund benefits under any employee benefit plan.

(m) "Long-term care insurance" means an insurance policy, rider, or certificate advertised, marketed, offered, or designed to provide coverage, subject to eligibility requirements, for not less than twenty-four consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides at least the benefits set forth in part fifty-two of title eleven of the official compilation of codes, rules and regulations of this state.

§ 7. Subsection (a) of section 7706 of the insurance law, as added by chapter 802 of the laws of 1985, is amended to read as follows:

(a) There is created a not-for-profit corporation to be known as "The Life and Health Insurance Company Guaranty Corporation of New York". To the extent that the provisions of the not-for-profit corporation law do not conflict with the provisions of this article or the plan of operation of the corporation hereunder the not-for-profit corporation law shall apply to the corporation and the corporation shall be a type C corporation pursuant to the not-for-profit corporation law. If an appli-

cable provision of this article or the plan of operation of the corporation hereunder relates to a matter embraced in a provision of the not-for-profit corporation law but is not in conflict therewith, both provisions shall apply. All member insurers shall be and remain members of the corporation as a condition of their authority to transact insurance in this state. The corporation shall perform its functions under the plan of operation established and approved under section seven thousand seven hundred ten of this article and shall exercise its powers through a board of directors established under section seven thousand seven hundred seven of this article. For purposes of administration and assessment the corporation shall maintain two accounts:

(1) the health insurance account; and

(2) the life insurance, annuity and funding agreement account.

§ 8. Subsection (d) of section 7707 of the insurance law, as added by chapter 802 of the laws of 1985, is amended to read as follows:

(d) The superintendent shall be ex-officio [~~chairman~~] **chair** of the board of directors but shall not be entitled to vote.

§ 9. Paragraph 7 of subsection (h) of section 7708 of the insurance law, as amended by chapter 454 of the laws of 2014, is amended to read as follows:

(7) exercise, for the purposes of this article and to the extent approved by the superintendent, the powers of a domestic life**, health, or property/casualty** insurance company, but in no case may the corporation issue insurance policies **or contracts** or annuity contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer;

§ 10. Paragraph 2 of subsection (c) of section 7709 of the insurance law, as added by chapter 802 of the laws of 1985, is amended to read as follows:

(2) The amount of any class B or class C assessment**, except for assessments related to long-term care insurance,** shall be allocated for assessment purposes among the accounts in the proportion that the premiums received by the impaired or insolvent insurer on the policies or contracts covered by each account for the last calendar year preceding the assessment in which the impaired or insolvent insurer received premiums bears to the premiums received by such insurer for such calendar year on all covered policies. **The amount of any class B or class C assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the superintendent. The methodology shall provide for fifty percent of the assessment to be allocated to a health insurance company member insurer and fifty percent to be allocated to a life insurance company member insurer; provided, however, that a property/casualty insurer that writes health insurance shall be considered a health insurance company member for this purpose.** Class B and class C assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the three calendar years preceding the assessment bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

§ 11. Subsection (a) of section 7712 of the insurance law, as added by chapter 802 of the laws of 1985, is amended to read as follows:

(a) The superintendent shall annually, within six months following the close of each calendar year, furnish to the commissioner of taxation and finance and the director of the division of the budget a statement of

operations for the life insurance guaranty corporation and the life **and health** insurance company guaranty corporation of New York. Such statement shall show the assessments, less any refunds or reimbursements thereof, paid by each insurance company pursuant to the provisions of article seventy-five or section seven thousand seven hundred nine of this article, for the purposes of meeting the requirements of this chapter. Each statement, starting with the statement furnished in the year nineteen hundred eighty-six and ending with the statement furnished in the year two thousand, shall show the annual activity for every year commencing from nineteen hundred eighty-five through the most recently completed year. Each statement furnished in each year after the year two thousand shall reflect such assessments paid during the preceding fifteen calendar years. The superintendent shall also furnish a copy of such statement to each such insurance company.

§ 12. Subsections (a), (d), and (g) of section 7719 of the insurance law, as added by chapter 454 of the laws of 2014, are amended to read as follows:

(a) The corporation may incorporate one or more not-for-profit corporations, known as a resolution facility, in connection with the liquidation of an insolvent domestic life insurance company**, health insurance company, or property/casualty insurance company** under article seventy-four of this chapter for the purpose of administering and disposing of the business of the insolvent [~~**domestic life**~~] insurance company.

(d) A resolution facility may:

(1) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies, or arrange for replacement by policies found by the superintendent to be substantially similar to the covered policies;

(2) exercise, for the purposes of this article and to the extent approved by the superintendent, the powers of a domestic life insurance company, **health insurance company, or property/casualty insurance company** but in no case may the resolution facility issue insurance policies, annuity contracts, funding agreements, or supplemental contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer;

(3) assure payment of the contractual obligations of the insolvent insurer; and

(4) provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge its duties.

(g) (1) If the superintendent determines that the resolution facility is not administering and disposing of the business of an insolvent domestic life insurance company**, health insurance company, or property/casualty insurance company** consistent with the resolution facility's certificate of incorporation, plan of operation, or this section, then the superintendent shall provide notice to the resolution facility and the resolution facility shall have thirty days to respond to the superintendent and cure the defect.

(2) If, after thirty days, the superintendent continues to believe that the resolution facility is not administering and disposing of the business of an insolvent domestic life insurance company**, health insurance company, or property/casualty insurance company** consistent with the resolution facility's certificate of incorporation, plan of operation, or this section, then the superintendent may apply to the court for an order directing the resolution facility to correct the defect or take other appropriate actions.

§ 13. The insurance law is amended by adding a new section 7720 to read as follows:

§ 7720. Penalties. (a) If any member insurer fails to make any payment required by this article, or if the superintendent has cause to believe that any other statement filed is false or inaccurate in any particular, or that any payment made is incorrect, the superintendent may examine all the books and records of the member insurer to ascertain the facts and determine the correct amount to be paid. Based on such finding, the corporation may proceed in any court of competent jurisdiction to recover for the benefit of the fund any sums shown to be due upon such examination and determination.

(b) Any member insurer that fails to make any such required statement, or to make any payment to the fund when due, shall forfeit to the corporation for deposit in the fund a penalty of five percent of the amount determined to be due plus one percent of such amount for each month of delay, or fraction thereof, after the expiration of the first month of such delay. If satisfied that the delay was excusable, the corporation may remit all or any part of the penalty.

(c) The superintendent, in the superintendent's discretion, may revoke the certificate of authority to do business in this state of any foreign member insurer that fails to comply with this article or to pay any penalty imposed hereunder.

§ 14. The insurance law is amended by adding a new section 3245 to read as follows:

§ 3245. Liability to providers in the event of an insolvency. In the event an insurance company authorized to do an accident and health insurance business in this state is deemed insolvent, as provided in section one thousand three hundred nine of this chapter, no insured covered under a policy delivered or issued for delivery in this state by the insurance company shall be liable to any provider of health care services for any covered services of the insolvent insurance company. No provider of health care services or any representative of such provider shall collect or attempt to collect from the insured sums owed by such insurance company, and no provider or representative of such provider may maintain any action at law against an insured to collect sums owed to such provider by such insurance company.

§ 15. 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 Subparts A through D of this act shall be as specifically set forth in the last section of such Subparts.

PART Z

Section 1. Subdivisions 7 and 8 of section 4656 of the public health law, as added by chapter 2 of the laws of 2004, are renumbered subdivisions 8 and 9 and a new subdivision 7 is added to read as follows:

7. Assisted living quality improvement standards. (a) All assisted living residences, as defined in subdivision one of section forty-six hundred fifty-one of this article, including those licensed and certified as an assisted living residence, special needs assisted living residence, or enhanced assisted living residence, shall:

(i) report annually on quality measures to be established by the department, in the form and format prescribed by the department, with the first report due no later than January thirty-first, two thousand twenty-four; and

(ii) post the monthly service rate, staffing complement, approved admission or residency agreement, and a consumer-friendly summary of all service fees in a conspicuous place on the facility's website and in a public space within the facility. Such information shall be made available to the public on forms developed by the department. Beginning on January first, two thousand twenty-four, this information shall also be reported to the department.

(b) The department shall score the results of the assisted living quality reporting obtained pursuant to paragraph (a) of this subdivision. Top scoring facilities shall be granted the classification of advanced standing on their annual surveillance schedules.

(i) All facilities shall be surveyed on an unannounced basis no less than annually; provided, however, that this shall not apply to surveys, inspections or investigations based on complaints received by the department under any other provision of law.

(ii) Facilities may remain on advanced standing classification provided they meet the scoring requirements in assisted living quality reporting.

(c) Effective January thirty-first, two thousand twenty-four, the department may post on its website the results of the assisted living quality reporting, collected pursuant to subparagraph (i) of paragraph (a) of this subdivision.

§ 2. This act shall take effect on the one hundred twentieth day after it shall have become a law.

PART AA

Section 1. Section 3 of chapter 425 of the laws of 2013, amending the public health law relating to requiring hospitals to offer hepatitis C testing, as amended by chapter 284 of the laws of 2019, is amended to read as follows:

§ 3. This act shall take effect on the first of January next succeeding the date on which it shall have become a law [~~and shall expire and be deemed repealed January 1, 2026; provided, however, that the commissioner of health is authorized to adopt rules and regulations necessary to implement this act prior to such effective date~~].

§ 2. Subdivisions 1 and 2 of section 2171 of the public health law, as added by chapter 425 of the laws of 2013, are amended to read as follows:

1. Every individual [~~born between the years of nineteen hundred forty-five and nineteen hundred sixty-five~~] age eighteen and older (or younger than eighteen if there is evidence or indication of risk activity) who receives health services as an inpatient or in the emergency department of a general hospital defined in subdivision ten of section twenty-eight hundred one of this chapter or who receives primary care services in an outpatient department of such hospital or in a diagnostic and treatment center licensed under article twenty-eight of this chapter

or from a physician, physician assistant [~~or~~], nurse practitioner **or midwife** providing primary care shall be offered a hepatitis C screening test [~~or hepatitis C diagnostic test~~] unless the health care practitioner providing such services reasonably believes that:

(a) the individual is being treated for a life threatening emergency; or

(b) the individual has previously been offered or has been the subject of a hepatitis C screening test (except that a test shall be offered if otherwise indicated); or

(c) the individual lacks capacity to consent to a hepatitis C screening test.

2. If an individual accepts the offer of a hepatitis C screening test and the screening test is reactive, [~~the~~] **an HCV RNA test must be performed, on the same specimen or a second specimen collected at the same time as the initial HCV screening test specimen, to confirm diagnosis of current infection. The** health care provider shall either offer [~~the individual~~] **all persons with a detectable HCV RNA test** follow-up **HCV** health care **and treatment** or refer the individual to a health care provider who can provide follow-up **HCV** health care **and treatment**. [~~The follow-up health care shall include a hepatitis C diagnostic test.~~]

§ 3. The public health law is amended by adding a new section 2500-l to read as follows:

§ 2500-l. Pregnant people, blood test for hepatitis C virus (HCV); follow-up care. 1. Every physician or other authorized practitioner attending a pregnant person in the state shall order a hepatitis C virus (HCV) screening test and if the test is reactive, an HCV RNA test must be performed on the same specimen, or a second specimen collected at the same time as the initial HCV screening test specimen, to confirm diagnosis of current infection. The health care provider shall either offer all persons with a detectable HCV RNA test follow-up HCV health care and treatment or refer the individual to a health care provider who can provide follow-up HCV health care and treatment.

2. The physician or other authorized practitioner attending a pregnant person shall record the HCV test results prominently in the pregnant person's medical record at or before the time of hospital admission for delivery.

3. The commissioner may promulgate such rules and regulations as are necessary to carry out the requirements of this section.

§ 4. The section heading of section 2308 of the public health law, as amended by section 37 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

Sexually transmitted disease; pregnant [~~women~~] **persons**; blood test for syphilis.

§ 5. Subdivision 1 of section 2308 of the public health law is amended to read as follows:

1. Every physician **or other authorized practitioner** attending pregnant [~~women~~] **persons** in the state shall in the case of every [~~woman~~] **person** so attended take or cause to be taken a sample of blood of such [~~woman~~] **person** at the time of first examination, and submit such sample to an approved laboratory for a standard serological test for syphilis. **In addition to testing at the time of first examination, every such physician or other authorized practitioner shall order a syphilis test during the third trimester of pregnancy consistent with any guidance and regulations issued by the commissioner.**

§ 6. This act shall take effect immediately; provided, however that sections two, three, four and five shall take effect one year 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 BB

Intentionally Omitted

PART CC

Intentionally Omitted

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 2023-24 cost of living adjustment (COLA), effective April 1, 2023, 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, 2023 through March 31, 2024, the commissioners shall provide funding to support an eight and five-tenths percent (8.5%) cost of living adjustment under this section for all eligible programs and services as determined pursuant to subdivision four of this section.

2-a. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefor, for state fiscal years beginning April 1, 2024 and thereafter, the commissioners shall provide funding to support an annual cost of living adjustment under this section in an amount equal to the consumer price index - urban (CPI-U) from the previous July, published by the bureau of labor statistics of the U.S. Department of Labor, 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 8.5 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, 2023. Except for the 8.5 percent cost of living adjustment (COLA) established herein, for the period commencing on April 1, 2023 and ending March 31, 2024 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. This subdivision shall not prevent the office of children and family services from applying additional trend factors or staff retention factors to eligible programs and services under paragraph (v) of subdivision four of this section.

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; 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-executive clinical staff, or respond to other critical non-personal service

costs prior to supporting any salary increases or other compensation for executive level job titles.

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, 2023.

PART EE

Section 1. Subdivision 1-a of section 84 of part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, as amended by section 9 of part Z of chapter 57 of the laws of 2018, is amended to read as follows:

1-a. sections seventy-three through eighty-a shall expire and be deemed repealed September 30, [~~2023~~] 2024;

§ 2. This act shall take effect immediately.

PART FF

Section 1. Subparagraph (v) of paragraph (a) of subdivision 1 of section 6908 of the education law is renumbered subparagraph (vi) and a new subparagraph (v) is added to read as follows:

(v) tasks provided by a direct support staff in non-facility based programs certified, authorized or approved by the office for people with developmental disabilities, so long as such staff do not hold himself or herself out as one who accepts employment solely for performing such care, and where nursing services are under the instruction of a service recipient or family or household member determined by a registered professional nurse to be capable of providing such instruction. In the event that the registered nurse determines that the service recipient, family, or household member is not capable of providing such instruction, nursing tasks may be performed by direct support staff pursuant to subparagraph (vi) of this paragraph subject to the requirements set forth therein; or

§ 2. This act shall take effect immediately.

PART GG

Intentionally Omitted

PART HH

Section 1. Sections 36.01, 36.02 and 36.03 of the mental hygiene law are renumbered sections 36.02, 36.03 and 36.04 and a new section 36.01 is added to read as follows:

§ 36.01 General applicability.

The office of mental health and the office of addiction services and supports shall be authorized to receive from the division of criminal justice services criminal history information, as such term is defined in paragraph (c) of subdivision one of section eight hundred forty-five-b of the executive law, concerning each applicant to be a provider of services or operator of such provider of services, and shall securely exchange information with confidentiality between the office of mental health and the office of addiction services and supports to facilitate a single criminal history information process for providers of services licensed, certified, or otherwise authorized jointly or by both of the offices pursuant to this article or articles thirty-one and thirty-two of this title.

§ 2. The mental hygiene law is amended by adding two new sections 36.05 and 36.06 to read as follows:

§ 36.05 Certified community behavioral health clinics.

(a) The commissioners are authorized to jointly certify community behavioral health clinics, subject to the availability of state and federal funding.

(b) Certified community behavioral health clinics shall provide coordinated, comprehensive behavioral health care, including mental health and addiction services, primary care screening, and case management services, in accordance with certified community behavioral health clinic standards established by the United States department of health and human services substance abuse and mental health services administration and the commissioners of the office of mental health and the office of addiction services and supports.

(c) The commissioners shall require each proposed certified community behavioral health clinic to submit a plan, which shall be approved by the commissioners prior to the issuance of an operating certificate pursuant to this article. Such plan shall include:

(1) a description of the clinic's character and competency to provide certified community behavioral health clinic services across the lifespan, including how the clinic will ensure access to crisis services at all times and accept all patients regardless of ability to pay;

(2) a description of the clinic's catchment area;

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

(4) where executed, agreements establishing formal relationships with designated collaborating organizations to provide certain certified community behavioral health clinic services, consistent with guidance issued by the United States department of health and human services substance abuse and mental health services administration and the office of mental health and the office of addiction services and supports;

(5) a staffing plan driven by local needs assessment, licensing, and training to support service delivery;

(6) a description of the clinic's data-driven approach to quality improvement;

(7) a description of how consumers are represented in governance of the clinic;

(8) all financial information in the form and format required by the office of mental health and the office of addiction services and supports; and

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

(d) Where a certified community behavioral health clinic has been established and is participating on the effective date of this section in the federal certified community behavioral health clinic demonstration awarded to the state by the United States department of health and human services substance abuse and mental health services administration, the previously established clinic may be certified where the clinic demonstrates compliance with the certification standards established pursuant to this article.

(e) The commissioners shall promulgate any rule or regulation necessary to effectuate this section.

§ 36.06 Certified community behavioral health clinics indigent care program.

(a) (1) For periods on and after July first, two thousand twenty-three, the commissioners are authorized to make payment to eligible certified community behavioral health clinics, to the extent of funds appropriated therefor to assist in meeting losses resulting from uncompensated care. In the event federal financial participation is not available for such payments to eligible certified community behavioral health clinics, payments shall be made solely on the basis of available state general fund appropriations for this purpose in amounts to be determined by the director of the division of the budget.

(2) For purposes of this section, "eligible certified community behavioral health clinics" shall mean voluntary non-profit certified community behavioral health clinics participating in the federal certified community behavioral health clinic demonstration awarded to the state by the United States department of health and human services substance abuse and mental health services administration and other certified community behavioral health clinics certified pursuant to section 36.05 of this article, which demonstrate that a minimum of three percent of total visits reported during the applicable base year period, as determined by the commissioners, were to uninsured individuals.

(3) For purposes of this section, "losses resulting from uncompensated care" shall mean losses from reported self-pay and free visits multiplied by the clinic's medical assistance payment rate for the applicable distribution year, offset by payments received from such patients during the reporting period.

(b) A certified community behavioral health clinic qualifying for a distribution pursuant to this section shall provide assurances satisfactory to the commissioners that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third-party insurance payors, governmental payors and self-paying patients.

(c) (1) Funding pursuant to this section shall be allocated to eligible certified community behavioral health clinics based on actual, reported losses resulting from uncompensated care in a given base year period and shall not exceed one hundred percent of an eligible clinic's losses in the same period.

(2) If the sum of actual, reported losses resulting from uncompensated care for all certified community behavioral health clinics exceeds the amount appropriated therefor in a given base year period, allocations of funds for each eligible certified community behavioral health clinic shall be assessed proportionately based upon the percentage of the total number of uncompensated care visits for all clinics that each clinic provided during the base year and shall not exceed amounts appropriated in the aggregate.

(d) Except as provided in subdivision (e) of this section, for periods on and after July first, two thousand twenty-three through June thirtieth, two thousand twenty-six, funds shall be made available for payments pursuant to this section for eligible certified community behavioral health clinics for the following periods in the following aggregate amounts:

(1) For the period of July first, two thousand twenty-three through June thirtieth, two thousand twenty-four, up to twenty-two million five hundred thousand dollars;

(2) For the period of July first, two thousand twenty-four through June thirtieth, two thousand twenty-five, up to forty-one million two hundred fifty thousand dollars; and

(3) For the period of July first, two thousand twenty-five through June thirtieth, two thousand twenty-six, up to forty-five million dollars.

(e) In the event that federal financial participation is not available for rate adjustments pursuant to this section, funds available for payments pursuant to this section for each eligible certified community behavioral health clinic shall be limited to the non-federal share equivalent of the amounts specified in subdivision (d) of this section.

(f) Eligible certified community behavioral health clinics receiving funding under this section shall not be eligible for comprehensive diagnostic and treatment centers indigent care program funding pursuant to section two thousand eight hundred seven-p of the public health law.

(g) The commissioners may require facilities receiving distributions pursuant to this section as a condition of participating in such distributions, to provide reports and data to the office of mental health and the office of addiction services and supports as the commissioners deem necessary to adequately implement the provisions of this section.

§ 3. This act shall take effect immediately.

PART II

Section 1. This Part enacts into law major components of legislation relating to improving access to behavioral health services. Each component is wholly contained within a Subpart identified as Subparts A through F. 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 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 Part.

SUBPART A

Section 1. Item (i) of subparagraph (A) of paragraph 35 of subsection (i) of section 3216 of the insurance law, as amended by chapter 818 of the laws of 2022, is amended to read as follows:

(i) where the policy provides coverage for inpatient hospital care, such policy shall include benefits: for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~and benefits for~~]; sub-acute care in a medically-monitored residential facility licensed, operated, or otherwise authorized by the office of

mental health; outpatient care provided [~~in~~] by a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law[~~,~~] or [~~in~~] by a facility operated by the office of mental health[~~, or in~~]; outpatient care provided by a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law[~~,~~]; outpatient care provided by a mobile crisis intervention services provider licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health; outpatient care for care coordination services, critical time intervention services, and assertive community treatment services, provided by facilities licensed, operated, or otherwise authorized by the office of mental health, following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of a hospital licensed pursuant to article twenty-eight of the public health law; or, for care provided in other states, to similarly licensed or certified hospitals [~~or~~], facilities, or providers; and

§ 2. Items (iii) and (iv) of subparagraph (E) of paragraph 35 of subsection (i) of section 3216 of the insurance law, as added by section 8 of subpart A of part BB of chapter 57 of the laws of 2019, are amended and two new items (v) and (vi) are added to read as follows:

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; [~~and~~]

(iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases[~~.~~];

(v) "assertive community treatment" means an evidence-based, mobile, psychiatric treatment intervention, designed for an individual with a serious mental health condition who is at risk for hospitalization, that includes psychotherapy, medication therapy, crisis intervention, psychiatric rehabilitation, care coordination, and peer support services, provided assertively in the community; and

(vi) "critical time intervention services" means evidence-based, time-limited, therapeutic interventions that begin before an individual is discharged from an inpatient setting, that include intensive outreach, engagement, and care coordination services to stabilize the individual in the community.

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

(I) This subparagraph shall apply to mobile crisis intervention services providers licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of

children and family services, or department of health. For purposes of this subparagraph, "mobile crisis intervention services" means mental health and substance use disorder services, including assessment and treatment services and peer support services, provided to an individual experiencing an acute psychological crisis or acute emotional distress in relation to a mental health condition or substance use disorder, intended to ameliorate the crisis and stabilize the individual and ensure ongoing stabilization after the initial crisis response.

(i) Benefits for covered services provided by a mobile crisis intervention services provider shall not be subject to preauthorization.

(ii) Benefits for covered services provided by a mobile crisis intervention services provider shall be covered regardless of whether the mobile crisis intervention services provider is a participating provider.

(iii) If the covered services are provided by a non-participating mobile crisis intervention services provider, an insurer shall not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to covered services received from a participating mobile crisis intervention services provider.

(iv) If the covered services are provided by a non-participating mobile crisis intervention services provider, the insured's copayment, coinsurance, and deductible shall be the same as would apply if such covered services were provided by a participating mobile crisis intervention services provider.

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

(J) This subparagraph shall apply to school-based mental health clinics that are licensed pursuant to article thirty-one of the mental hygiene law and provide outpatient care in pre-school, elementary, or secondary schools. An insurer shall provide reimbursement for covered outpatient care when provided by such school-based mental health clinics at a pre-school, elementary, or secondary school, regardless of whether the school-based mental health clinic furnishing such services is a participating provider with respect to such services. Reimbursement for such covered services shall be at the rate negotiated between the insurer and school-based mental health clinic or, in the absence of a negotiated rate, an amount no less than the rate that would be paid for such services pursuant to the medical assistance program under title eleven of article five of the social services law. Payment by an insurer pursuant to this section shall be payment in full for the services provided. The school-based mental health clinic reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against, an insured for the services provided pursuant to this subparagraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the policy.

§ 5. Item (i) of subparagraph (A) of paragraph 5 of subsection (l) of section 3221 of the insurance law, as amended by section 14 of part AA of chapter 57 of the laws of 2021, is amended to read as follows:

(i) where the policy provides coverage for inpatient hospital care, benefits for: inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~and benefits for~~]; sub-acute care in a medically-monitored residential facility licensed, operated, or otherwise authorized by the office of mental health; outpatient care provided [~~in~~] by a facility issued an operating certificate by the

commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or [~~in~~] by a facility operated by the office of mental health [~~or in~~]; outpatient care provided by a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law; outpatient care provided by a mobile crisis intervention services provider licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health; outpatient care for care coordination services, critical time intervention services, and assertive community treatment services, provided by facilities licensed, operated, or otherwise authorized by the office of mental health or the department of health, following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of a hospital licensed pursuant to article twenty-eight of the public health law; or, for care provided in other states, to similarly licensed or certified hospitals [~~or~~], facilities, or providers; and

§ 6. Items (iii) and (iv) of subparagraph (E) of paragraph 5 of subsection (l) of section 3221 of the insurance law, as added by section 14 of subpart A of part BB of chapter 57 of the laws of 2019, are amended and two new items (v) and (vi) are added to read as follows:

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; [~~and~~]

(iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases[~~.~~];

(v) "assertive community treatment" means an evidence-based, mobile, psychiatric treatment intervention, designed for people with a serious mental health condition who are at risk for hospitalization, that includes psychotherapy, medication therapy, crisis intervention, psychiatric rehabilitation, care coordination, and peer support services, provided assertively in the community; and

(vi) "critical time intervention services" means evidence-based, time-limited, therapeutic interventions that begin before an individual is discharged from an inpatient setting, that include intensive outreach, engagement, and care coordination services to stabilize individuals in the community.

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

(I) This subparagraph shall apply to mobile crisis intervention services providers licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health. For purposes of

this subparagraph, "mobile crisis intervention services" means mental health and substance use disorder services, including assessment and treatment services and peer support services, provided to an individual experiencing an acute psychological crisis or acute emotional distress in relation to a mental health condition or substance use disorder, intended to ameliorate the crisis and stabilize the individual and ensure ongoing stabilization after the initial crisis response.

(i) Benefits for covered services provided by a mobile crisis intervention services provider shall not be subject to preauthorization.

(ii) Benefits for covered services provided by a mobile crisis intervention services provider shall be covered regardless of whether the mobile crisis intervention services provider is a participating provider.

(iii) If the covered services are provided by a non-participating mobile crisis intervention services provider, an insurer shall not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to covered services received from a participating mobile crisis intervention services provider.

(iv) If the covered services are provided by a non-participating mobile crisis intervention services provider, the insured's copayment, coinsurance, and deductible shall be the same as would apply if such covered services were provided by a participating mobile crisis intervention services provider.

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

(J) This subparagraph shall apply to school-based mental health clinics that are licensed pursuant to article thirty-one of the mental hygiene law and provide outpatient care in pre-school, elementary, or secondary schools. An insurer shall provide reimbursement for covered outpatient care when provided by such school-based mental health clinics at a pre-school, elementary, or secondary school, regardless of whether the school-based mental health clinic furnishing such services is a participating provider with respect to such services. Reimbursement for such covered services shall be at the rate negotiated between the insurer and school-based mental health clinic or, in the absence of a negotiated rate, an amount no less than the rate that would be paid for such services pursuant to the medical assistance program under title eleven of article five of the social services law. Payment by an insurer pursuant to this section shall be payment in full for the services provided. The school-based mental health clinic reimbursed pursuant to this section shall not charge or seek any reimbursement from or have any recourse against, an insured for the services provided pursuant to this subparagraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the policy.

§ 9. Paragraph 1 of subsection (g) of section 4303 of the insurance law, as amended by section 18 of part AA of chapter 57 of the laws of 2021, is amended to read as follows:

(1) where the contract provides coverage for inpatient hospital care, benefits for: in-patient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~or for inpatient care provided in other states, to similarly licensed hospitals, and benefits for~~]; sub-acute care in a medically-monitored residential facility licensed, operated, or otherwise authorized by the office of mental health; [~~out-patient~~] outpatient care provided [~~in~~] by a facility issued

an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law or [~~in~~] by a facility operated by the office of mental health [~~or in~~]; outpatient care provided by a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law; outpatient care provided by a mobile crisis intervention services provider licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health; outpatient care for care coordination services, critical time intervention services, and assertive community treatment services, provided by facilities licensed, operated, or otherwise authorized by the office of mental health or the department of health, following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of a hospital licensed pursuant to article twenty-eight of the public health law; or for [~~out-patient~~] care provided in other states, to similarly licensed or certified hospitals, facilities, or providers; and

§ 10. Subparagraphs (C) and (D) of paragraph 6 of subsection (g) of section 4303 of the insurance law, as added by section 23 of subpart A of part BB of chapter 57 of the laws of 2019, are amended and two new subparagraphs (E) and (F) are added to read as follows:

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; [~~and~~]

(D) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases[~~.~~];

(E) "assertive community treatment" means an evidence-based, mobile, psychiatric treatment intervention, designed for an individual with a serious mental health condition who is at risk for hospitalization, that includes psychotherapy, medication therapy, crisis intervention, psychiatric rehabilitation, care coordination, and peer support services, provided assertively in the community; and

(F) "critical time intervention services" means evidence-based, time-limited, therapeutic interventions that begin before an individual is discharged from an inpatient setting, that include intensive outreach, engagement, and care coordination services to stabilize individuals in the community.

§ 11. Subsection (g) of section 4303 of the insurance law is amended by adding a new paragraph 10 to read as follows:

(10) This paragraph shall apply to mobile crisis intervention services providers licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health. For purposes of this para-

graph, "mobile crisis intervention services" means mental health and substance use disorder services, including assessment and treatment services and peer support services, provided to an individual experiencing an acute psychological crisis or acute emotional distress in relation to a mental health condition or substance use disorder, intended to ameliorate the crisis and stabilize the individual and ensure ongoing stabilization after the initial crisis response.

(A) Benefits for covered services provided by a mobile crisis intervention services provider shall not be subject to preauthorization.

(B) Benefits for covered services provided by a mobile crisis intervention services provider shall be covered regardless of whether the mobile crisis intervention services provider is a participating provider.

(C) If the covered services are provided by a non-participating mobile crisis intervention services provider, a corporation shall not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to covered services received from a participating mobile crisis intervention services provider.

(D) If the covered services are provided by a non-participating mobile crisis intervention services provider, the insured's copayment, coinsurance, and deductible shall be the same as would apply if such covered services were provided by a participating mobile crisis intervention services provider.

§ 12. Subsection (g) of section 4303 of the insurance law is amended by adding a new paragraph 11 to read as follows:

(11) This paragraph shall apply to school-based mental health clinics that are licensed pursuant to article thirty-one of the mental hygiene law and provide outpatient care in pre-school, elementary, or secondary schools. A corporation shall provide reimbursement for covered outpatient care when provided by such school-based mental health clinics at a pre-school, elementary, or secondary school, regardless of whether the school-based mental health clinic furnishing such services is a participating provider with respect to such services. Reimbursement for such covered services shall be at the rate negotiated between the corporation and school-based mental health clinic or, in the absence of a negotiated rate, an amount no less than the rate that would be paid for such services pursuant to the medical assistance program under title eleven of article five of the social services law. Payment by a corporation pursuant to this section shall be payment in full for the services provided. The school-based mental health clinic reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against, a corporation for the services provided pursuant to this paragraph, except for the collection of in-network copayments, coinsurance, or deductibles for which the insured is responsible for under the terms of the contract.

§ 13. Paragraphs 1 and 2 of subsection (a) of section 605 of the financial services law, as amended by section 5 of subpart A of part AA of chapter 57 of the laws of 2022, are amended to read as follows:

(1) When a health care plan receives a bill for emergency services from a non-participating provider, including a bill for inpatient services which follow an emergency room visit, or a bill for services from a mobile crisis intervention services provider licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health, 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 **or for the mobile crisis intervention services**, rendered by the non-participating 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 **or for the mobile crisis intervention services**, than the insured would have incurred with a participating provider. The non-participating 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 provider the amount prescribed by this section and any subsequent amount determined to be owed to the provider in relation to the emergency services provided, including inpatient services which follow an emergency room visit **or for the mobile crisis intervention services**.

(2) A non-participating 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, **or for services rendered by a mobile crisis intervention services provider licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health,** for review to an independent dispute resolution entity.

§ 14. Subsection (b) of section 606 of the financial services law, as amended by section 7 of subpart A of part AA of chapter 57 of the laws of 2022, is amended to read as follows:

(b) A non-participating provider shall not bill an insured for emergency services, including inpatient services which follow an emergency room visit**, or for services rendered by a mobile crisis intervention services provider licensed, certified, or authorized by the office of mental health, office of addiction services and supports, office of children and family services, or department of health**, except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating provider.

§ 15. This act shall take effect January 1, 2024; provided, however, that sections one through twelve of this act shall apply to policies and contracts issued, renewed, amended, modified or altered on or after such date.

SUBPART B

Section 1. Subparagraphs (G) and (H) of paragraph 35 of subsection (i) of section 3216 of the insurance law, subparagraph (G) as added by section 8 of subpart A of part BB of chapter 57 of the laws of 2019 and subparagraph (H) as added by section 13 of part AA of chapter 57 of the laws of 2021, are amended to read as follows:

(G) This subparagraph shall apply to hospitals **and medically-monitored crisis residential facilities** in this state that are licensed**, operated, or otherwise authorized** by the office of mental health that are participating in the insurer's provider network. Where the policy provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~**provided to individuals who have not attained the age of eighteen**~~] **and benefits for sub-acute care in a medically-monitored crisis residential facility licensed, operated, or otherwise**

authorized by the office of mental health shall not be subject to preauthorization. Coverage provided under this subparagraph shall also not be subject to concurrent utilization review for individuals who have not attained the age of eighteen during the first fourteen days of the inpatient admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the [~~patient~~] insured, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the [~~patient~~] insured, to ensure that the inpatient care is medically necessary for the [~~patient~~] insured. For individuals who have attained age eighteen, coverage provided under this subparagraph shall also not be subject to concurrent review during the first thirty days of the inpatient or residential admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the insured, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the insured, to ensure that the inpatient or residential care is medically necessary for the insured. However, concurrent review may be performed during the first thirty days if an insured meets clinical criteria designated by the office of mental health or where the insured is admitted to a hospital or facility which has been designated by the office of mental health for concurrent review, in consultation with the commissioner of health and the superintendent. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

§ 2. Subparagraphs (G) and (H) of paragraph 5 of subsection (l) of section 3221 of the insurance law, subparagraph (G) as added by section 14 of subpart A of part BB of chapter 57 of the laws of 2019 and subparagraph (H) as added by section 15 of part AA of chapter 57 of the laws of 2021, are amended to read as follows:

(G) This subparagraph shall apply to hospitals and medically-monitored crisis residential facilities in this state that are licensed, operated, or otherwise authorized by the office of mental health that are participating in the insurer's provider network. Where the policy provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~provided to individuals who have not attained the age of eighteen~~] and benefits for sub-acute care in a medically-monitored crisis residential facility, operated or otherwise authorized by

the office of mental health shall not be subject to preauthorization. Coverage provided under this subparagraph shall also not be subject to concurrent utilization review **for individuals who have not attained the age of eighteen** during the first fourteen days of the inpatient admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the [~~patient~~] **insured**, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the [~~patient~~] **insured** to ensure that the inpatient care is medically necessary for the [~~patient~~] **insured. For individuals who have attained age eighteen, coverage provided under this subparagraph shall also not be subject to concurrent review during the first thirty days of the inpatient or residential admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the insured, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the insured, to ensure that the inpatient or residential care is medically necessary for the insured. However, concurrent review may be performed during the first thirty days if an insured meets clinical criteria designated by the office of mental health or where the insured is admitted to a hospital or facility which has been designated by the office of mental health for concurrent review, in consultation with the commissioner of health and the superintendent**. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

§ 3. Paragraphs 8 and 9 of subsection (g) of section 4303 of the insurance law, paragraph 8 as added by section 23 of subpart A of part BB of chapter 57 of the laws of 2019 and paragraph 9 as added by section 19 of part AA of chapter 57 of the laws of 2021, are amended to read as follows:

(8) This paragraph shall apply to hospitals **and medically-monitored crisis residential facilities** in this state that are licensed**, operated or otherwise authorized** by the office of mental health that are participating in the corporation's provider network. Where the contract provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law [~~provided to individuals who have not attained the age of eighteen~~] **and benefits for sub-acute care in a medically-monitored crisis residential facility licensed, operated, or**

otherwise authorized by the office of mental health shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review for individuals who have not attained the age of eighteen during the first fourteen days of the inpatient admission, provided the facility notifies the corporation of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the [~~patient~~] insured, and participates in periodic consultation with the corporation to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the corporation which is approved by the office of mental health and appropriate to the age of the [~~patient~~] insured, to ensure that the inpatient care is medically necessary for the [~~patient~~] insured. For individuals who have attained age eighteen, coverage provided under this paragraph shall also not be subject to concurrent review during the first thirty days of the inpatient or residential admission, provided the facility notifies the corporation of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the insured, and participates in periodic consultation with the corporation to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the corporation which is approved by the office of mental health and appropriate to the age of the insured, to ensure that the inpatient or residential care is medically necessary for the insured. However, concurrent review may be performed during the first thirty days if an insured meets clinical criteria designated by the office of mental health or where the insured is admitted to a hospital or facility which has been designated by the office of mental health for concurrent review, in consultation with the commissioner of health and the superintendent. All treatment provided under this paragraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

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

§ 4. Paragraph 12 of subsection (a) of section 4902 of the insurance law, as added by section 38 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(12) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria designated by the commissioner of the office of mental health for level of care determinations, in consultation with the superintendent and commissioner of health. For coverage determinations outside the scope of the criteria designated for level of care determinations, the utilization review agent shall use clinical review criteria deemed appropriate and approved

for such use by the commissioner of the office of mental health, in consultation with the commissioner of health and the superintendent. Approved clinical review criteria shall have inter rater reliability testing completed [~~by December thirty-first, two thousand nineteen~~] prior to implementation.

§ 5. Paragraph (j) of subdivision 1 of section 4902 of the public health law, as added by section 43 of subpart A of part BB of chapter 57 of the laws of 2019, is amended to read as follows:

(j) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria designated by the commissioner of the office of mental health for level of care determinations, in consultation with the commissioner and the superintendent of financial services. For coverage determinations outside the scope of the criteria designated for level of care determinations, the utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner and the superintendent of financial services. Approved clinical review criteria shall have inter rater reliability testing completed [~~by December thirty-first, two thousand nineteen~~] prior to implementation.

§ 6. This act shall take effect one year 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.

SUBPART C

Section 1. Paragraph 2 of subsection (a) of section 3217-h of the insurance law, as added by section 3 of part V of chapter 57 of the laws of 2022, is amended to read as follows:

(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. Notwithstanding the provisions of this paragraph, services provided by facilities licensed, certified or otherwise authorized pursuant to article sixteen, thirty-one, thirty-two or thirty-six of the mental hygiene law, and deemed appropriate to be provided by telehealth by the commissioner of the office for people with developmental disabilities, the office of mental health, or the office of addiction services and supports, as applicable, shall be reimbursed at the same rate as is reimbursed when delivered in person.

§ 2. Paragraph 2 of subsection (a) of section 4306-g of the insurance law, as added by section 4 of part V of chapter 57 of the laws of 2022, is amended to read as follows:

(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. **Notwithstanding the provisions of this paragraph, services provided by facilities licensed, certified or otherwise authorized pursuant to article sixteen, thirty-one, thirty-two or thirty-six of the mental hygiene law, and deemed appropriate to be provided by telehealth by the commissioner of the office for people with developmental disabilities, the office of mental health, or the office of addiction services and supports, as applicable, shall be reimbursed at the same rate as is reimbursed when delivered in person.**

§ 3. Subdivision 3 of section 4406-g of the public health law, as added by section 5 of part V of chapter 57 of the laws of 2022, is amended 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. **Notwithstanding the provisions of this subdivision, services provided by facilities licensed, certified or otherwise authorized pursuant to article sixteen, thirty-one, thirty-two or thirty-six of the mental hygiene law, and deemed appropriate to be provided by telehealth by the commissioner of the office for people with developmental disabilities, the office of mental health, or the office of addiction services and supports, as applicable, shall be reimbursed at the same rate as is reimbursed when delivered in person.**

§ 4. This act shall take effect immediately, and shall apply to claims submitted on or after such date; provided that:

(a) the amendments made to subsection (a) of section 3217-h of the insurance law made by section one of this act shall not affect the expiration and reversion of such subsection and shall be deemed to expire therewith;

(b) the amendments made to subsection (a) of section 4306-g of the insurance law made by section two of this act shall not affect the expiration and reversion of such subsection and shall be deemed to expire therewith; and

(c) the amendments made to subdivision 3 of section 4406-g of the public health law made by section three of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith.

SUBPART D

Section 1. Section 109 of the insurance law is amended by adding a new subsection (e) to read as follows:

(e) In addition to any right of action granted to the superintendent pursuant to this section, any person who has been injured by reason of a violation of paragraph thirty, thirty-one, thirty-one-a or thirty-five of subsection (i) of section thirty-two hundred sixteen, paragraph five, six, seven, seven-a or seven-b of subsection (l) of section thirty-two hundred twenty-one, or subsection (g), (k), (l), (l-1) or (l-2) of section forty-three hundred three of this chapter by an insurer, corporation, or health maintenance organization subject to article thirty-two or forty-three of this chapter may bring an action in the person's own name to recover the person's actual damages or one thousand dollars, whichever is greater; provided, however, that the provisions of this subsection shall not apply to any health plan that exclusively serves individuals enrolled pursuant to a federal or state insurance affordability program as defined in section two hundred sixty-eight-a of the public health law, the medical assistance program under title eleven of article five of the social services law, child health plus under title one-A of article twenty-five of the public health law, the basic health program under section three hundred sixty-nine-gg of the social services law, or a plan providing services under title XVIII of the federal Social Security Act. The court may, in its discretion, award the prevailing plaintiff in such action an additional award not to exceed five thousand dollars if the court finds a willful violation pursuant to this subsection. The court may award reasonable attorneys' fees to a prevailing plaintiff.

§ 2. This act shall take effect immediately.

SUBPART E

Section 1. Subparagraph (A) of paragraph 31-a of subsection (i) of section 3216 of the insurance law, as added by chapter 748 of the laws of 2019, is amended to read as follows:

(A) No policy that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone [~~or~~], long acting injectable naltrexone [~~for detoxification or maintenance treatment of a substance use disorder~~], or medication for opioid overdose reversal prescribed or dispensed to an individual covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law.

§ 2. Subparagraph (A) of paragraph 7-a of subsection (l) of section 3221 of the insurance law, as added by chapter 748 of the laws of 2019, is amended to read as follows:

(A) No policy that provides medical, major medical or similar comprehensive-type small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an individual covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose

reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law. Every policy that provides medical, major medical or similar comprehensive-type large group coverage shall provide coverage for prescription drugs for medication for the treatment of a substance use disorder and shall provide immediate coverage for all buprenorphine products, methadone [~~or~~], long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an individual covered under the policy, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, without prior authorization for the detoxification or maintenance treatment of a substance use disorder, except where otherwise prohibited by law.

§ 3. Paragraph (A) of subsection (l-1) of section 4303 of the insurance law, as added by chapter 748 of the laws of 2019, is amended to read as follows:

(A) No contract that provides medical, major medical or similar comprehensive-type individual or small group coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone, long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an individual covered under the contract, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, except where otherwise prohibited by law. Every contract that provides medical, major medical, or similar comprehensive-type large group coverage shall provide coverage for prescription drugs for medication for the treatment of a substance use disorder and shall provide immediate coverage for all buprenorphine products, methadone [~~or~~], long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an individual covered under the contract, including federal food and drug administration-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law, without prior authorization for the detoxification or maintenance treatment of a substance use disorder, except where otherwise prohibited by law.

SUBPART F

Section 1. Subsection (a) of 3241 of the insurance law, as added by section 6 of part H of chapter 60 of the laws of 2014, is amended to read as follows:

(a) (1) An insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a health insurance policy or contract with a network of health care providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The superintendent shall review the network of health care providers for adequacy at the time of the superintendent's initial approval of a health insurance policy or

contract; at least every three years thereafter; and upon application for expansion of any service area associated with the policy or contract in conformance with the standards set forth in subdivision five of section four thousand four hundred three of the public health law. To the extent that the network has been determined by the commissioner of health to meet the standards set forth in subdivision five of section four thousand four hundred three of the public health law, such network shall be deemed adequate by the superintendent.

(2) The superintendent, in consultation with the commissioner of health, the commissioner of the office of mental health, and the commissioner of the office of addiction services and supports, shall promulgate regulations setting forth standards for network adequacy for mental health and substance use disorder treatment. Such standards shall include:

(A) requirements that ensure that insureds have timely and proximate access to treatment for mental health conditions and substance use disorders;

(B) appointment availability standards that include timeframes for initial provider visits, follow-up provider visits, and provider visits following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of a hospital licensed pursuant to article twenty-eight of the public health law;

(C) time and distance standards that take into consideration reasonable proximity to the insured's residence, established service delivery patterns for the area, the geographic area, and the availability of telehealth services; and

(D) responsibilities of an insurer to provide an out-of-network referral at the in-network cost-sharing when there is no participating provider able to provide the requested health care service within the timely and proximate access standards established by regulation and a non-participating provider is able to meet such standards; and, where the non-participating provider is a facility licensed, operated, or otherwise authorized by the office of mental health or the office of addiction services and supports, the insurer shall reimburse the facility at a rate negotiated between the insurer and facility, or in the absence of a negotiated rate, an amount no less than the rate that would be paid for such services pursuant to the medical assistance program under title eleven of article five of the social services law.

§ 2. Subdivision 5 of section 4403 of the public health law is amended by adding a new paragraph (d) to read as follows:

(d) The commissioner, in consultation with the superintendent of financial services, the commissioner of the office of mental health, and the commissioner of the office of addiction services and supports, shall promulgate regulations setting forth standards for network adequacy for mental health and substance use disorder treatment. Such standards shall include:

(i) requirements that ensure that enrollees have timely and proximate access to treatment for mental health conditions and substance use disorders;

(ii) appointment availability standards that include timeframes for initial provider visits, follow-up provider visits, and provider visits following discharge from a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law or the emergency department of a hospital licensed pursuant to article twenty-eight of the public health law;

(iii) time and distance standards that take into consideration reasonable proximity to the enrollee's residence, established service delivery patterns for the area, the geographic area, and the availability of telehealth services; and

(iv) responsibilities of an organization to provide an out-of-network referral at the in-network cost-sharing when there is no participating provider able to provide the requested health care service within the timely and proximate access standards established by regulation and a non-participating provider is able to meet such standards; and, where the non-participating provider is a facility licensed, operated, or otherwise authorized by the office of mental health or the office of addiction services and supports, the organization shall reimburse the facility at a rate negotiated between the organization and facility or, in the absence of a negotiated rate, an amount no less than the rate that would be paid for such services pursuant to the medical assistance program under title eleven of article five of the social services law.

§ 3. This act shall take effect immediately.

§ 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 date of Subparts A through F of this act shall be as specifically set forth in the last section of such Subparts.

PART JJ

Section 1. Subdivision (g) of section 31.16 of the mental hygiene law, as amended by chapter 351 of the laws of 1994, is amended and two new subdivisions (g-1) and (g-2) are added to read as follows:

(g) The commissioner may impose [~~a fine~~] sanctions upon a finding that the holder of the certificate has failed to comply with the terms of the operating certificate [~~or with the provisions of any applicable statute, rule or regulation~~] in relation to inpatient bed levels. The commissioner shall be authorized to develop a schedule for the purpose of imposing such sanctions. The maximum amount of [~~such fine~~] sanctions imposed thereunder shall not exceed [~~one~~] two thousand dollars per day [~~or fifteen thousand dollars~~], per violation. Sanctions may be considered at the individual bed level for beds closed without authorization at inpatient settings.

Such [~~penalty~~] sanctions may be recovered by an action brought by the commissioner in any court of competent jurisdiction.

Such [~~penalty~~] sanctions may be released or compromised by the commissioner before the matter has been referred to the attorney general. Any such [~~penalty~~] sanction may be released or compromised and any action commenced to recover the same may be settled or discontinued by the attorney general with the consent of the commissioner.

(g-1) Such sanctions under subdivision (g) of this section shall account for mitigating factors which shall include:

(i) any officially declared national, state, or municipal emergency;

(ii) any unforeseen disaster or other catastrophic event that immediately affects or increases the need for health care services;

(iii) the frequency and nature of non-compliance; and

(iv) any other mitigating factors established through regulation.

(g-2) In determining whether an operating certificate holder has violated its obligation to comply with the terms of the operating certificate in relation to inpatient bed levels, it shall not be a defense that the operator was unable to secure proper staff or other necessary resources if the lack of staff or other resources was foreseeable and could be prudently planned for or involved routine staffing needs that arose due to typical staffing patterns, typical levels of absenteeism, and time off typically approved by the operator for vacation, holidays, sick leave, and personal leave.

§ 2. This act shall take effect immediately.

PART KK

Section 1. Subparagraph (i) of paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by section 2 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(i) personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), (iv)[~~, (v)~~] and (vi) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a qualified independent physician selected or approved by the department of health, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

§ 2. Subparagraph (v) of paragraph (e) of subdivision 2 of section 365-a of the social services law is REPEALED.

§ 3. Paragraph (c) of subdivision 2 of section 365-f of the social services law, as amended by section 3 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(c) has been determined by the social services district, pursuant to an assessment of the person's appropriateness for the program, conducted with an appropriate long term home health care program, a certified home health agency, or an AIDS home care program or pursuant to the personal care program, as being in need of home care services or private duty nursing and [~~as needing at least limited assistance with physical manuevering with more than two activities of daily living, or for persons with a dementia or Alzheimer's diagnosis, as needing at least supervision with more than one activity of daily living, provided that the provisions related to activities of daily living in this paragraph shall only apply to persons who initially seek eligibility for the program on or after October first, two thousand twenty, and~~] who is able and willing or has a designated representative, including a legal guardian able and willing to make informed choices, or a designated relative or other adult who is able and willing to assist in making informed choices, as to the type and quality of services, including but not limited to such

services as nursing care, personal care, transportation and respite services; and

§ 4. This act shall take effect immediately.

PART LL

Section 1. Legislative findings and intent. The legislature finds that:

a. According to a 2020 report by the Women's Media Center there are 64,000-75,000 missing black women and girls across the United States.

b. Cases involving black women and girls often do not receive the attention they need and there are often barriers to families reporting a loved one, such as mistrust of police, and racial disparities in how law enforcement treat disappearances.

c. The tens of thousands of black women and girls who are missing include abductees, sex trafficking victims, and runaways. Black women and girls exist at the intersection of racism and sexism, and often face worse health, wealth, housing, education, and employment outcomes.

d. Black girls comprise over 40% of domestic sex trafficking victims in the United States.

e. Law enforcement often categorize missing black girls as runaways and fail to treat their cases with urgency.

f. According to a 2020 report by the Sovereign Bodies Institute, a nonprofit, indigenous-led research organization, at least 2,306 missing Native American women and girls have gone missing in the last 40 years in the United States, about 1,800 of whom were killed or vanished.

g. Systemic vulnerability and compounding suppressions have resulted in mass amounts of disappeared indigenous peoples, with the National Congress of American Indians finding that an estimated 40% of women who are victims of sex trafficking identify as American Indian, Alaska Native, or First Nations.

h. Families of Native American women and girls who have gone missing report a lack of cultural awareness, systemic racism and sexism, and widespread apathy by law enforcement and express frustration that their cases are not pursued.

i. There is not comprehensive state or federal data about missing and murdered Native Americans. Advocates argue that poor record keeping, racial misclassification, adverse relationships between tribal governments and outside law enforcement have led to an underreporting of cases.

§ 2. a. There is hereby established a task force on missing women and girls who are black, indigenous and people of color (BIPOC). Such task force shall be composed of the commissioner of the office of family and children's services, the commissioner of the division of criminal justice services, the superintendent of state police, or the designees of such commissioners and superintendent. Additional members shall be appointed as follows, two shall be appointed by the temporary president of the senate, two shall be appointed by the speaker of the assembly, one shall be appointed by the minority leader of the senate, and one shall be appointed by the minority leader of the assembly. Members shall be representative of the communities experiencing this crisis, including directly impacted individuals, reflect the diversity of New York state, and have experience in cultural competency.

b. Task force members shall receive no compensation for their services but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.

c. The task force shall:

(i) develop policy changes that will work to address the lack of care and concern for missing and murdered BIPOC women and girls with New York state governmental agencies, including identifying policies to ensure first responders are culturally competent;

(ii) advance the knowledge of communities on the severity of BIPOC women and girls who are missing and murdered;

(iii) ensure BIPOC communities are educated and trained on the prevention, protection, and protocols relating to missing BIPOC women and girls as it relates to social media;

(iv) develop a strategy to collect statistics, demographics, surveys, oral histories, and data analysis;

(v) recommend preventive programming and ideas to advance the safety of women and girls, including policies that address the overlapping forms of oppression faced by BIPOC women and girls;

(vi) identify major traffic hubs, highways, and resource extraction sites that lead to or are responsible for the facilitation of the abduction of BIPOC women and girls; and

(vii) create a state-wide awareness campaign.

d. In carrying out the duties of the task force, such task force shall seek public input by holding public hearings in each region of the state and accepting public input in writing.

e. On or before two years after the effective date of this act, the task force shall submit to the temporary president of the senate, the speaker of the assembly, the minority leader of the senate and the minority leader of the assembly a report containing its findings and recommendations. Such reports shall be made available to the public.

§ 3. This act shall take effect on the sixtieth day after it shall have become a law and shall expire and be deemed repealed three years after such date.

PART MM

Section 1. Subdivision (f) of section 19.17 of the mental hygiene law, as amended by section 1 of part K of chapter 58 of the laws of 2009, is amended to read as follows:

(f) There shall be in the office the facilities named below for the care, treatment and rehabilitation of the mentally disabled and for clinical research and teaching in the science and skills required for the care, treatment and rehabilitation of such mentally disabled. **Such facilities are authorized to provide treatment for the mental health and health care needs of individuals admitted for a substance use disorder, provided, further, that the mental health and health care services shall be reimbursable by Medicaid and private insurance. Mental health services shall be provided by a professional whose scope of practice includes the diagnosis and treatment of mental health disorders. Health care services shall be provided by a health care professional whose scope of practice includes diagnosing and treating human responses to actual or potential health problems. The office shall consult with the office of mental health and the department of health to assure that applicable rules and regulations of such agencies are complied with. Nothing in this section shall preclude these facilities from transferring a person to a different facility in the event the person's mental health or health care needs are deemed to exceed the treatment capacity of such facility.**

R.E. Blaisdell Addiction Treatment Center

Bronx Addiction Treatment Center
C.K. Post Addiction Treatment Center
Creedmoor Addiction Treatment Center
Dick Van Dyke Addiction Treatment Center
Kingsboro Addiction Treatment Center
McPike Addiction Treatment Center
Richard C. Ward Addiction Treatment Center
J.L. Norris Addiction Treatment Center
South Beach Addiction Treatment Center
St. Lawrence Addiction Treatment Center
Stutzman Addiction Treatment Center
§ 2. This act shall take effect immediately.

PART NN

Section 1. The mental hygiene law is amended by adding a new section 33.28 to read as follows:

§ 33.28 Independent developmental disability ombudsman program.

(a) There is hereby established by the office for people with developmental disabilities the independent developmental disability ombudsman program for the purpose of assisting individuals with developmental disabilities to ensure their access to services and preservation of their rights.

(b) Such ombudsman program shall have the following duties, including, but not limited to:

1. establishing a service delivery structure based in New York state that includes a toll-free telephone hotline, an interactive website, and availability of in-person, telephone and email access to ombudsman program staff or volunteers;

2. identifying, investigating, referring and resolving complaints made by, or on behalf of, individuals relative to their access to services provided by the office for people with developmental disabilities or the care coordination provided by health homes serving individuals with developmental disabilities or services provided by other providers;

3. providing assistance for navigating and completing processes, such as paperwork and documentation, to access services provided by the office for people with developmental disabilities or the care coordination provided by health homes serving individuals with developmental disabilities to individuals or services provided by other providers, and/or anyone seeking assistance on their behalf;

4. assisting individuals in filing and preparing appeals, and representing individuals in appeals and hearings concerning adverse benefit determinations regarding services provided by the office for people with developmental disabilities or health homes serving individuals with developmental disabilities to individuals or services provided by other providers;

5. collecting, tracking, and quantifying problems and inquiries encountered by individuals; and

6. educating individuals on their rights and responsibilities with respect to access to services provided by the office for people with developmental disabilities and care coordination provided by health homes serving individuals with developmental disabilities or services provided by other providers.

(c) Notices and materials provided to individuals by the office for people with developmental disabilities, providers of services, and the health homes serving individuals with developmental disabilities shall

include the name, phone number and website address of the independent developmental disability ombudsman program established by the office for people with developmental disabilities pursuant to this section.

(d) Funds available for expenditure pursuant to this section for the establishment of an independent developmental disability ombudsman program may be allocated and distributed by the commissioner of the office for people with developmental disabilities, subject to the approval of the director of the budget, but only after the commissioner of the office for people with developmental disabilities holds a request for proposal process for the establishment of an independent developmental disability ombudsman program. Only domestic not-for-profit corporations shall be eligible to submit proposals for such program. Entities that currently receive funding from the office for people with developmental disabilities to provide services to people with developmental disabilities, or to operate care coordination organizations, or that bill the Medicaid program for medical or healthcare services, shall be excluded from consideration. The commissioner of the office for people with developmental disabilities shall consider all competitive proposals submitted through such request for proposal process and shall determine which proposal submitted is appropriate for the establishment of an independent developmental disability ombudsman program. In making such determination, applicants who demonstrate experience providing advocacy or assistance to people with developmental disabilities, experience operating a call center, or experience tracking and reporting on case activities while protecting individual confidentiality shall receive deference for the award.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law.

PART OO

Section 1. Clause (vi) of subparagraph 1 of paragraph (e) of subdivision 5 of section 366 of the social services law, as amended by section 13 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(vi) "look-back period" means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance, or in the case of a non-institutionalized individual, subject to federal approval, for transfers made on or after October first, two thousand twenty, the thirty-month period immediately preceding the date that such non-institutionalized individual applies for medical assistance coverage of long term care services. Nothing herein precludes a review of eligibility for retroactive authorization for medical expenses incurred during the three months prior to the month of application for medical assistance.

§ 2. Clauses (iii) and (iv) of subparagraph 4 of paragraph (e) of subdivision 5 of section 366 of the social services law, as added by section 26-a of part C of chapter 109 of the laws of 2006, are amended and a new clause (v) is added to read as follows:

(iii) a satisfactory showing is made that: (A) the individual or the individual's spouse intended to dispose of the assets either at fair market value, or for other valuable consideration; or (B) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or (C) all assets transferred for less than fair market value have been returned to the individual or used on the individual's behalf; or

(iv) denial of eligibility would cause an undue hardship, such that application of the transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter, or other necessities of life. The commissioner of health shall develop a hardship waiver process which shall include a timely process for determining whether an undue hardship waiver will be granted and a timely process under which an adverse determination can be appealed. The commissioner of health shall provide notice of the hardship waiver process in writing to those individuals who are required to comply with the transfer of assets provision under this section. If such an individual is an institutionalized individual, the facility in which he or she is residing shall be permitted to file an undue hardship waiver application on behalf of such individual with the consent of the individual or the personal representative of the individual[~~.~~]**; or**

(v) the transfer was to a family member or informal caregiver before the current period of institutional status, or before the application for Medicaid for non-institutional long-term care services, and all the following conditions are met:

(A) the transfer is in exchange for care services the family member or informal caregiver provided to the client or the client's spouse;

(B) the client or the client's spouse had a documented need for the care services provided by the family member or informal caregiver;

(C) the fair market value of the asset transferred is comparable to the fair market value of the care services provided; and

(D) the time for which care services are claimed is reasonable based on the kind of services provided.

§ 3. Subparagraph 5 of paragraph (e) of subdivision 5 of section 366 of the social services law, as added by section 26-a of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(5) Any transfer made by an individual or the individual's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for services for a period equal to the total, cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average monthly costs of nursing facility services provided to a private patient for a given period of time at the time of application, as determined pursuant to the regulations of the department. For purposes of this subparagraph, the average monthly costs of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing facilities within the region where the applicant resides, as established pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law. The period of ineligibility shall begin the first day of a month during or after which assets have been transferred for less than fair market value, or**, (i) for institutionalized individuals,** the first day the otherwise eligible individual is receiving services for which medical assistance coverage would be available based on an approved application for such care but for the provisions of subparagraph three of this paragraph, whichever is later, and which does not occur in any other periods of ineligibility under this paragraph**, or (ii) for non-institutionalized individuals, the first day the otherwise eligible individual is functionally eligible for services for which medical assistance would be available based on an approved application for such care but for the provisions of subparagraph three of this para-**

graph, whichever is later, and which does not occur in any other periods of ineligibility under this paragraph.

§ 4. Subdivision 12 of section 366-a of the social services law, as added by section 36-c of part B of chapter 57 of the laws of 2015, is amended to read as follows:

12. The commissioner shall develop expedited procedures for determining medical assistance eligibility for any medical assistance applicant with an immediate need for personal care or consumer directed personal assistance services pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of this title or section three hundred sixty-five-f of this title, respectively. Such procedures shall require that a final eligibility determination be made within seven days of the date of a [~~complete~~] medical assistance application that shall be complete, except that a non-institutionalized individual applicant may attest that no transfers of assets were made within the look-back period under subdivision five of section three hundred sixty-six of this title; provided the non-institutionalized individual applicant shall submit complete documentation of assets during the look-back period within thirty days of the date the application was filed.

§ 5. This act shall take effect immediately.

PART PP

Section 1. The public health law is amended by adding a new section 2807-nn to read as follows:

§ 2807-nn. Reproductive health training and education grant program. 1. As used in this section, "eligible participant" means an intern or resident who is employed by a hospital or otherwise enrolled in an accredited graduate medical education program.

2. The commissioner, shall establish a reproductive health services training and education grant program for eligible participants as defined in subdivision one of this section. Such grant program shall consist of two to six weeks of clinical training in accordance with Accreditation Council for Graduate Medical Education standards for clinical training in the performance of abortion and related reproductive health services and shall otherwise meet professionally recognized training standards as defined by the commissioner.

3. The commissioner is authorized, within amounts appropriated for such purpose to make grants in accordance with this subdivision. Such grants may be used for administration, faculty recruitment and development, start-up costs and costs incurred teaching reproductive health care in hospital-based programs or non-hospital-based care sites, including, but not limited to, personnel, administration and trainee related expenses and other expenses judged reasonable and necessary by the commissioner. As used in this section, "trainee related expenses" shall include a travel and housing stipend paid to each intern or resident if deemed necessary.

§ 2. The state finance law is amended by adding a new section 99-qq to read as follows:

§ 99-qq. Reproductive health training and education fund. 1. There is hereby established in the joint custody of the state comptroller and commissioner of taxation and finance a special fund to be known as the "reproductive health training and education fund".

2. Such fund shall consist of all moneys appropriated thereto from any other fund or source pursuant to law. Nothing contained in this section shall prevent the state from receiving grants, gifts or bequests for the

purposes of the fund as defined in this section and depositing them into the fund according to law.

3. Moneys shall be payable from the fund on the audit and warrant of the comptroller on vouchers approved and certified by the commissioner of health.

4. The moneys in such fund shall be expended for the reproductive health services training and education grant program in accordance with the provisions of section twenty-eight hundred seven-nn of the public health law.

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

PART QQ

Section 1. The public health law is amended by adding a new section 207-b to read as follows:

§ 207-b. Women's health education program in state and local correctional facilities. The commissioner, in consultation with the commissioner of corrections and community supervision and the chair of the state commission of correction, shall establish a women's health education program in state and local correctional facilities. Such program shall educate facility medical staff on the special medical needs of women, including training on providing professional, respectful and informed care of women who have been victims of domestic violence or sexual violence.

§ 2. Subdivision 1 of section 2308-a of the public health law, as amended by section 38 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

1. The administrative officer or other person in charge of a clinic or other facility providing gynecological, obstetrical, genito-urological, contraceptive, sterilization or termination of pregnancy services or treatment shall require the staff of such clinic or facility to offer to administer to every resident of the state of New York coming to such clinic or facility for such services or treatment, appropriate examinations or tests for the detection of sexually transmitted diseases. For the purposes of this subdivision, the term "facility" shall include a correctional facility as defined in subdivision four of section two of the correction law.

§ 3. Subdivision 2 of section 140 of the correction law, as added by chapter 516 of the laws of 1995, is amended to read as follows:

2. Subject to the regulations of the department of health, routine medical, dental and mental health services and treatment is defined for the purposes of this section to mean any routine diagnosis or treatment, including without limitation the provision of gynecological services for female incarcerated individuals, the administration of medications or nutrition, the extraction of bodily fluids for analysis, and dental care performed with a local anesthetic. Routine mental health treatment shall not include psychiatric administration of medication unless it is part of an ongoing mental health plan or unless it is otherwise authorized by law.

§ 4. Subdivision 2 of section 505 of the correction law, as added by chapter 437 of the laws of 2013, is amended to read as follows:

2. Subject to the regulations of the department of health, routine medical, dental and mental health services and treatment is defined for the purposes of this section to mean any routine diagnosis or treatment, including without limitation **the provision of gynecological services for female incarcerated individuals,** the administration of medications or nutrition, the extraction of bodily fluids for analysis, and dental care performed with a local anesthetic. Routine mental health treatment shall not include psychiatric administration of medication unless it is part of an ongoing mental health plan or unless it is otherwise authorized by law.

§ 5. The correction law is amended by adding a new section 140-a to read as follows:

§ 140-a. Prenatal care. If a pregnant woman is confined to a state or local correctional facility, she shall be given prenatal care comparable to such care available to women in the community. Such care shall include regular check-ups throughout the course of her pregnancy and education on healthy lifestyle choices of benefit to the woman and her child. Pregnant women confined to such facilities shall also be given prenatal vitamins and a specialized diet tailored to provide their nutritional needs during pregnancy.

§ 6. The commissioner of corrections and community supervision, in conjunction with the commissioner of health shall promulgate such rules and regulations as may be necessary to effectuate the provisions of section five of this act.

§ 7. 1. The department of health, in cooperation with the department of corrections and community supervision, shall conduct a study of women's health care in prisons. Such study shall:

a. collect all available data relating to women's health care in prisons;

b. determine how often women in prisons are being seen by a medical professional;

c. determine how long it takes for women in prisons to be seen by a medical professional;

d. identify what issues women in prisons are most often being seen for;

e. determine the outcomes of women in prisons being seen by a medical professional; and

f. investigate anything deemed relevant by the commissioner of health or the commissioner of corrections and community supervision for the purposes of this study.

2. Upon completion of the study required by subdivision one of this section, the commissioner of health, or his or her designee, shall prepare a report to be given to the governor and the legislature which shall include the findings of such study. Such report shall be filed within one year of the effective date of this act, unless the commissioner of health requests in writing, an extension of time.

3. All other departments or agencies of the state or subdivisions thereof, and local governments shall, at the request of the commissioner of health or the commissioner of corrections and community supervision, provide expertise, assistance, and data that will enable such commissioner to carry out his or her powers and duties.

§ 8. This act shall take effect immediately; provided, however, that section five of this act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for

the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART RR

Section 1. Subdivision 2 of section 3614-f of the public health law, as added by section 1 of part XX of chapter 56 of the laws of 2022, is amended to read as follows:

2. In addition to the otherwise applicable minimum wage under section six hundred fifty-two of the labor law, or any otherwise applicable wage rule or order under article nineteen of the labor law, the minimum wage for a home care aide shall be increased by an amount of [~~three~~] **five** dollars and zero cents in accordance with the following schedule:

(a) beginning October first, two thousand twenty-two, the minimum wage for a home care aide shall be increased by an amount of two dollars and zero cents, [~~and~~]

(b) beginning October first, two thousand twenty-three, the minimum wage for a home care aide shall be increased by an additional amount of one dollar and zero cents[~~.~~] **,**

(c) beginning October first, two thousand twenty-four, the minimum wage for a home care aide shall be increased by an additional amount of one dollar and zero cents, and

(d) beginning October first, two thousand twenty-five, the minimum wage for a home care aide shall be increased by an additional amount of one dollar and zero cents.

§ 2. Section 3614-f of the public health law is amended by adding a new subdivision 4 to read as follows:

4. The commissioner shall submit any and all necessary applications for approvals and/or waivers to the federal centers for medicare and medicaid services to make state-directed payments to providers for the purposes of supporting wage increases.

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

(b) If the state directed payment is not approved, the department shall require plans to justify deviations apart from the minimum hourly base reimbursement rates.

§ 3. To ensure compliance with this minimum wage increase, the comptroller shall have the authority to review the contracts entered into between a managed care organization and a licensed home care services agency, fiscal intermediary, or any agency subject to the provisions of section 3614-f of the public health law to ensure that rates being offered are adequate and meet the department of health's actuarial standards. The comptroller, in consultation with the medicaid fraud control unit, may develop and promulgate a process to ensure such audits comply with state and federal law to protect proprietary information and contracts. In the event that the comptroller finds evidence that managed care organizations are not paying sufficient adequate rates, they will refer such instances to the department of health and the medicaid fraud control unit for enforcement. If the department of health or the medicaid fraud control unit chooses not to pursue action related to this referral, it shall inform, in writing, the comptroller's office as to the reasoning. Such reports, and the department of health's responses, shall be public information and made available on the comptroller's website. For the purposes of this section, the term "managed care organ-

ization" shall mean an entity operating pursuant to section 364-j of the social services law or article 44 of the public health law.

§ 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 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 immediately and shall be deemed to have been in full force and effect on and after April 1, 2023.

PART SS

Section 1. Paragraph (d) of subdivision 1 of section 364-j of the social services law, as amended by chapter 653 of the laws of 1997, is amended to read as follows:

(d) "Medical services provider". A physician, nurse, nurse practitioner, physician assistant, licensed midwife, **doula,** dentist, optometrist or other licensed health care practitioner authorized to provide medical assistance services.

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

(kk) doula care services for physical, emotional, and informational support to pregnant people before, during, and after delivery. This shall include, but not be limited to, antepartum visits, labor and delivery attendance, and postpartum visits.

§ 3. The commissioner of health is directed to apply for such state Medicaid plan amendments or waivers as may be necessary to implement the provisions of this act and include doula care as a covered service under the state Medicaid plan, and to secure federal financial participation for state Medicaid expenditures for doula care under the federal Medicaid program.

§ 4. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023 and thereafter, Medicaid reimbursement for doulas shall be at least one thousand nine hundred thirty dollars for four antepartum visits, labor and delivery attendance, and four postpartum visits, subject to the approval of the commissioner and the director of the division of the budget.

§ 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023; provided, however, that the amendments to section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART TT

Section 1. The commissioner of health shall conduct a study to review the rates of reimbursement made through the New York state Medicaid durable medical equipment, orthotics, prosthetics and supplies program for rate adequacy and patient access, including those made under all capitated and contract coverage models. Such review shall include:

(a) an analysis of rules, regulations and policies for orthotics and prosthetics service/device provisions under the New York Medicaid program, including all contracted and capitated models;

(b) a comprehensive assessment of the existing methodology used to determine payment or nonpayment for prosthetic and orthotic care including but not limited to:

(i) all orthotic and prosthetic codes on the current Medicaid fee schedule, including but not limited to a comparison of prevailing Medicare fee schedule amounts and New York Medicaid amounts;

(ii) codes on the Medicare fee schedule but not included on the New York state Medicaid durable medical equipment, orthotics, prosthetics and supplies program fee schedule;

(iii) recommendations for changing reimbursement methodologies. Recommendations under this subparagraph shall be consistent with federal law and shall include recommendations for appropriate changes in state law and regulations. Such recommendations shall consider appropriate payment methodologies for codes not included on the Medicaid fee schedule;

(c) assessment of barriers to timely service provision as well as racial and socioeconomic disparities in access including, but not limited to, travel time required, geographic variability, access to and cost of technology;

(d) the workforce needed to provide orthotic and prosthetic services in the next five years to eligible children and adults, disaggregated by county;

(e) opportunities for stakeholder input on current rate methodologies; and

(f) assessment of cost savings associated with percentage of Medicaid population returning to work after orthotic and/or prosthetic provision.

§ 2. Within one year after the effective date of this act, the commissioner of health shall submit a report of the findings and recommendations pursuant to this act to the governor, the temporary president of the senate, the minority leader of the senate, the speaker of the assembly, the minority leader of the assembly, and the chairs and ranking members of the senate and assembly committees on health and shall post such report on the department of health's website.

§ 3. The commissioner of health shall be authorized to promulgate rules and regulations to provide for the orderly effectuation of the provisions of this act.

§ 4. This act shall take effect immediately and shall expire and be deemed repealed upon the submission of the report required pursuant to section two of this act; provided that the commissioner of health shall notify the legislative bill drafting commission upon the submission of the report required by section two of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART UU

Section 1. Paragraph (i) of subdivision 2 of section 2511 of the public health law is amended by adding two new subparagraphs (iii) and (iv) to read as follows:

(iii) A child who meets the eligibility criteria set forth in this subdivision or subdivision five of this section, as determined by an approved organization or the health insurance exchange marketplace, whichever is applicable, shall be enrolled retroactively to the first day of the month in which the application was submitted, provided that

the applicant for insurance submits a completed and signed application and required information and documentation within sixty days of the original application submission.

(iv) A child shall be presumed eligible for subsidy payments under this subdivision or eligible for coverage under subdivision five of this section, provided that the applicant for insurance submits a completed and signed application within sixty days of the application submission. Once eligibility is determined by the approved organization or the health insurance exchange marketplace, whichever is applicable, on the basis of preliminary information, the child shall be enrolled retroactively to the first day of the month in which the application was submitted. All other procedures and standards regarding presumptive enrollment applicable to eligible children enrolled under this title and specified in state contracts with approved organizations or implemented by the health insurance exchange marketplace, whichever is applicable, shall apply to presumptive enrollment of children.

§ 2. This act shall take effect immediately.

PART VV

Section 1. Sections 1 and 1-a of part FFF of chapter 56 of the laws of 2020 relating to directing the department of health to remove the pharmacy benefit from the managed care benefit package and to provide the pharmacy benefit under the fee for service program, are REPEALED.

§ 2. Subdivision 4 of section 364-j of the social services law is amended by adding four new paragraphs (x), (y), (z) and (aa) to read as follows:

(x) Notwithstanding any provision of law to the contrary, managed care providers under the medical assistance program and any pharmacy benefit managers acting on their behalf, as defined in section two hundred eighty-a of the public health law, shall be required to reimburse retail pharmacies for each outpatient drug, at the National Average Drug Acquisition Cost (NADAC), or if NADAC pricing is unavailable for a drug, reimbursement shall be pursuant to the current benchmarks under fee-for-service, plus a tiered professional dispensing fee based on prescription claims volume to be determined by the commissioner. In determining a professional dispensing fee, the commissioner shall issue a survey that collects claims volumes from enrolled pharmacies, and other such information as the commissioner may deem necessary to weigh regional variances and other factors significantly impacting markets from the previous twelve-month period, to determine the appropriate dispensing fee reimbursement. The dispensing fee determined by the commissioner shall be in an amount of at least ten dollars and eighteen cents.

(y) (i) Notwithstanding any provision of law to the contrary, a managed care provider or pharmacy benefit manager acting on its behalf, shall not deny any retail pharmacy the opportunity to participate in another provider's pharmacy network under the medical assistance program, provided that:

(A) such retail pharmacy agrees to the same reimbursement amount;

(B) is able to fill and dispense commonly dispensed prescriptions and over-the-counter medications in a manner consistent with medical assistance program guidance and statute for those patients and population the pharmacy serves enrolled in the medical assistance program;

(ii) Nothing in this paragraph shall require a managed care provider or pharmacy benefit manager to contract with a retail pharmacy or pharmacies that fail to meet universally accepted professional standards of

pharmacy practice. Further, nothing in this paragraph shall be construed as limiting the ability of managed care providers or pharmacy benefit managers to remove pharmacies from their network, or to decline to contract with pharmacies in cases of fraud, waste, abuse, or as otherwise authorized by law.

(z) (i) A managed care provider or pharmacy benefit manager acting on its behalf shall be required to reimburse 340B covered entity providers, whether directly or through arrangements with their contractual pharmacies, for outpatient drugs dispensed under section 340B of the federal public health service act (42 USCA § 256b), at NADAC, or if NADAC pricing is unavailable for a drug, reimbursement shall be pursuant to the current benchmarks under fee-for-service, plus a professional dispensing fee as determined by the commissioner pursuant to paragraph (x) of this subdivision.

(ii) Notwithstanding any provision of law to the contrary, rates of payment between covered entities under section 340B of the public health service act and contract pharmacies that obtain and dispense 340B drugs on behalf of the covered entity, shall comprise a fee schedule, based on fair market value principles and shall not be a percentage of either the claim's total reimbursement or net margin. The commissioner shall evaluate the adequacy of such fee schedule no less than every two years.

(aa) Notwithstanding any provision of law to the contrary, in order to align managed care provider drug formularies to reduce complexity for beneficiaries of medical assistance, and to maximize available federal statutory drug rebates for the state, managed care providers and any pharmacy benefit managers acting on their behalf, shall be required to use the fee-for-service preferred drug list when developing a formulary or preferred drug list of outpatients drugs for beneficiaries of medical assistance. In the interests of the creation of a high quality uniform formulary, and notwithstanding any provision of law to the contrary: the commissioner shall convene a committee comprised of the pharmacy directors of the state's currently participating managed care providers to advise in the creation and stewardship of any such formulary or preferred drug list.

§ 3. Section 280-a of the public health law is amended by adding a new subdivision 6 to read as follows:

6. Medical assistance delivery option. Notwithstanding any provision of law to the contrary, no pharmacy benefit manager shall limit the option for an individual exercising their benefits under the state's medical assistance program receiving prescription or over-the-counter medications to receive such medications from their local, non-mail order pharmacy of choice via delivery including in-person delivery, United States postal service or other mail or courier service. No restrictions, prohibitions, or prior authorization requirements shall be based on the individual's choice in delivery type or distance from a pharmacy.

§ 4. This act shall take effect immediately; provided, however, that sections two and three of this act shall be deemed to have been in full force and effect on and after April 1, 2023; provided, further, that the amendments to section 364-j of the social services law made by section two of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART WW

Section 1. Subdivision 1 and paragraph (d) of subdivision 2 of section 2808-e of the public health law, as added by section 1 of part MM of chapter 57 of the laws of 2021, are amended to read as follows:

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

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

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023; provided however that the amendments to section 2808-e of the public health law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART XX

Section 1. Subparagraph (vi) of paragraph (b) of subdivision 4 of section 365-h of the social services law, as added by section 2 of part LL of chapter 56 of the laws of 2020, is amended to read as follows:

(vi) [~~Responsibility~~] **The broker authorized under this paragraph shall not have responsibility** for transportation services provided or arranged for enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law, [~~not including~~] **nor** a program designated as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by Federal Public law 1053-33, subtitle I of title IV of the Balanced Budget Act of 1997[~~, and, at the commissioner's discretion, other plans that integrate benefits for dually eligible Medicare and Medicaid beneficiaries based on a demonstration by the plan that inclusion of transportation within the benefit package will result in cost efficiencies and quality improvement, shall be transferred to a transportation management broker that has a contract with the commissioner in accordance with this paragraph~~]. Providers of adult day health care may elect to, but shall not be required to, use the services of the transportation management broker.

§ 2. This act shall take effect immediately; provided that the amendments to subdivision 4 of section 365-h of the social services law shall be subject to the expiration and reversion of such section pursuant to subdivision (a) of section 40 of part B of chapter 109 of the laws of 2010, as amended, and shall be deemed to expire therewith.

PART YY

Section 1. The Department of Health shall not take any action to disenroll any participant in the Medicaid Health Home program based on the duration of time such participant has been enrolled in the program. If an appropriate health care provider makes a reasonable professional judgment, that health home services are medically necessary and warranted for an individual enrolled in the medical assistance program, established pursuant to title 11 of article 5 of the social services law, such individual shall be eligible to receive health home services; this shall not be deemed to infringe on any other methods to determine eligibility.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2023.

PART ZZ

Section 1. The office of mental health, in collaboration with the office of children and family services, shall convene a workgroup of individuals with expertise in suicide prevention for black children and youth.

(a) The following members, or their designees, shall participate in the workgroup: (1) the commissioner of the office of mental health; and (2) the commissioner of the office of children and family services. Additional members of the workgroup shall include, but not be limited to: physicians, nurses, therapists, social workers, and other professionals with experience researching, diagnosing, or treating black children and youth mental health issues and suicidality; and representatives of suicide prevention organizations that provide support and services to black youth and children and their families.

(b) The workgroup's focus shall include, but not be limited to: studying current mental health practices and suicide prevention efforts for black children and youth; identifying best mental health practices to improve the awareness and prevention of suicide for black children and youth; determining potential reasons for the black children and youth suicide rate; and recommending suicide prevention solutions for black children and youth.

(c) The workgroup shall convene no later than one hundred twenty days following the effective date of this act.

(d) The workgroup shall meet as frequently as its business may require and members of the workgroup shall receive no compensation for their participation.

(e) The office of mental health shall prepare a written report summarizing opinions and recommendations from the workgroup which includes a list of existing, publicly accessible resources on suicide prevention and awareness in black children and youth. This report shall be submitted to the governor, the speaker of the assembly, and the temporary president of the senate no later than two years following the effective date of this act and shall be posted on the office of mental health's website.

§ 2. The office of mental health, in collaboration with the office of children and family services, shall convene a workgroup of individuals with expertise in suicide prevention for latina children and youth.

(a) The following members, or their designees, shall participate in the workgroup: (1) the commissioner of the office of mental health; and (2) the commissioner of the office of children and family services. Additional members of the workgroup shall include, but not be limited to: physicians, nurses, therapists, social workers, and other profes-

sionals with experience researching, diagnosing, or treating latina children and youth mental health issues and suicidality; and representatives of suicide prevention organizations that provide support and services to latina children and youth and their families.

(b) The workgroup's focus shall include, but not be limited to: studying current mental health practices and suicide prevention efforts for latina children and youth; identifying best mental health practices to improve the awareness and prevention of suicide for latina children and youth; determining potential reasons for the latina children and youth suicide rate; and recommending suicide prevention solutions for latina children and youth.

(c) The workgroup shall convene no later than one hundred and twenty days following the effective date of this act.

(d) The workgroup shall meet as frequently as its business may require and members of the workgroup shall receive no compensation for their participation.

(e) The office of mental health shall prepare a written report summarizing opinions and recommendations from the workgroup which includes a list of existing, publicly accessible resources on suicide prevention and awareness in latina children and youth. This report shall be submitted to the governor, the speaker of the assembly, and the temporary president of the senate no later than two years following the effective date of this act and shall be posted on the office of mental health's website.

§ 3. The office of mental health, in collaboration with the office of children and family services, shall convene a workgroup of individuals with expertise in suicide prevention for LGBTQ+ children and youth.

(a) The term "LGBTQ+" shall mean lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, gender non-conforming and non-binary individuals.

(b) The following members, or their designees, shall participate in the workgroup: (1) the commissioner of the office of mental health; and (2) the commissioner of the office of children and family services. Additional members of the workgroup shall include, but not be limited to: physicians, nurses, therapists, social workers, and other professionals with experience researching, diagnosing, or treating LGBTQ+ children and youth mental health issues and suicidality; and representatives of suicide prevention organizations that provide support and services to LGBTQ+ children and youth and their families.

(c) The workgroup's focus shall include, but not be limited to: studying current mental health practices and suicide prevention efforts for LGBTQ+ children and youth; identifying best mental health practices to improve the awareness and prevention of suicide for LGBTQ+ children and youth; determining potential reasons for the LGBTQ+ children and youth suicide rate; and recommending suicide prevention solutions for LGBTQ+ children and youth.

(d) The workgroup shall convene no later than one hundred twenty days following the effective date of this act.

(e) The workgroup shall meet as frequently as its business may require and members of the workgroup shall receive no compensation for their participation.

(f) The office of mental health shall prepare a written report summarizing opinions and recommendations from the workgroup which includes a list of existing, publicly accessible resources on suicide prevention and awareness in LGBTQ+ children and youth. This report shall be submitted to the governor, the speaker of the assembly, and the temporary

president of the senate no later than two years following the effective date of this act and shall be posted on the office of mental health's website.

§ 4. This act shall take effect immediately; and shall expire and be deemed repealed after the required reports have been submitted to the governor, the speaker of the assembly, and the temporary president of the senate; provided that the office of mental health shall notify the legislative bill drafting commission upon the submission of such reports provided for in sections one, two and three of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART AAA

Section 1. Subdivision 2 of section 4900 of the public health law, as amended by chapter 586 of the laws of 1998, item (B) of subparagraph (ii) of paragraph (a) as amended by chapter 41 of the laws of 2014, subparagraph (iii) of paragraph (a) as amended by section 42 of subpart A of part BB of chapter 57 of the laws of 2019 and subparagraph (iv) of paragraph (a) and paragraph (b) as amended and subparagraph (v) of paragraph (a) as added by chapter 816 of the laws of 2022, is amended to read as follows:

2. "Clinical peer reviewer" means:

(a) [~~for purposes of title one of this article:~~

~~(i) a physician who possesses a current and valid non-restricted license to practice medicine; or~~

~~(ii) a health care professional other than a licensed physician who:~~

~~(A) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and~~

~~(B) is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review; or~~

~~(iii) for purposes of a determination involving substance use disorder treatment:~~

~~(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or~~

~~(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or~~

~~(iv) for purposes of a determination involving treatment for a mental health condition:~~

~~(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; or~~

~~(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of a mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or~~

~~(v) for purposes of a determination involving treatment of a medically fragile child:~~

~~(A) a physician who possesses a current and valid non-restricted license to practice medicine and who is board certified or board eligible in pediatric rehabilitation, pediatric critical care, or neonatology; or~~

~~(B) a physician who possesses a current and valid non-restricted license to practice medicine and is board certified in a pediatric subspecialty directly relevant to the patient's medical condition; and~~

~~(b) for purposes of title two of this article:~~

~~(i)~~] a physician who:

[~~(A)~~] (i) possesses a current and valid non-restricted license to practice medicine under article one hundred thirty-one of the education law;

[~~(B)~~] (ii) where applicable, is board certified or board eligible in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review or appeal;

[~~(C)~~] (iii) has been practicing in such area of specialty for a period of at least five years; [~~and~~

~~(D)~~] (iv) is knowledgeable about the health care service or treatment under review or appeal; or

[~~(ii)~~] (b) a health care professional other than a licensed physician who possesses a current and valid non-restricted license or certification under title eight of the education law:

[~~(A)~~] (i) where applicable, possesses a current and valid non-restricted license, certificate or registration;

[~~(B)~~] (ii) where applicable, is credentialed by the national accrediting body appropriate to the profession in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review or appeal;

[~~(C)~~] (iii) has been practicing in such area of specialty for a period of at least five years;

[~~(D)~~] (iv) is knowledgeable about the health care service or treatment under review or appeal; [~~and~~

~~(E)~~] (v) for purposes of a determination involving substance use disorder, specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

(vi) for purposes of a determination involving treatment for a mental health condition, specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or

registration exists, is credentialed by the national accrediting body appropriate to the profession; and

(vii) where applicable to such health care professional's scope of practice, is clinically supported by a physician who possesses a current and valid non-restricted license to practice medicine; or

[~~(iii)~~] (viii) for purposes of a determination involving treatment of a medically fragile child:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who is board certified or board eligible in pediatric rehabilitation, pediatric critical care, or neonatology, or

(B) a physician who possesses a current and valid non-restricted license to practice medicine and is board certified in a pediatric subspecialty directly relevant to the patient's medical condition.

[~~(c)~~] Nothing [~~herein~~] in this subdivision shall be construed to change any statutorily-defined scope of practice.

§ 2. Subsection (b) of section 4900 of the insurance law, as amended by chapter 586 of the laws of 1998, item (ii) of subparagraph (B) of paragraph 1 as amended by chapter 41 of the laws of 2014, subparagraph (C) of paragraph 1 as amended by section 36 of subpart A of part BB of chapter 57 of the laws of 2019 and subparagraph (D) of paragraph 1 and paragraph 2 as amended and subparagraph (E) of paragraph 1 as added by chapter 816 of the laws of 2022, is amended to read as follows:

(b) "Clinical peer reviewer" means:

(1) [~~for purposes of title one of this article:~~

~~(A) a physician who possesses a current and valid non-restricted license to practice medicine; or~~

~~(B) a health care professional other than a licensed physician who:~~

~~(i) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and~~

~~(ii) is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review; or~~

~~(C) for purposes of a determination involving substance use disorder treatment:~~

~~(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or~~

~~(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or~~

~~(D) for purposes of a determination involving treatment for a mental health condition:~~

~~(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; or~~

~~(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; or~~

~~(E) for purposes of a determination involving treatment of a medically fragile child:~~

~~(i) a physician who possesses a current and valid non-restricted license to practice medicine and who is board certified or board eligible in pediatric rehabilitation, pediatric critical care, or neonatology; or~~

~~(ii) a physician who possesses a current and valid non-restricted license to practice medicine and is board certified in a pediatric subspecialty directly relevant to the patient's medical condition; and~~

~~(2) for purposes of title two of this article:~~

~~(A)~~] a physician who:

[~~(i)~~] **(A)** possesses a current and valid non-restricted license to practice medicine **under article one hundred thirty-one of the education law**;

[~~(ii)~~] **(B)** where applicable, is board certified or board eligible in the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under **review or** appeal;

[~~(iii)~~] **(C)** has been practicing in such area of specialty for a period of at least five years; [~~and~~

~~(iv)~~] **(D) for purposes of a determination involving substance use disorder treatment, possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment;**

(E) for purposes of a determination involving treatment for a mental health condition, possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; and

(F) is knowledgeable about the health care service or treatment under **review or** appeal; or

[~~(B)~~] **(2)** a health care professional other than a licensed physician who **possesses a current and valid non-restricted license or certification under title eight of the education law**:

[~~(i)~~] **(A)** where applicable, possesses a current and valid non-restricted license, certificate or registration;

[~~(ii)~~] **(B)** where applicable, is credentialed by the national accrediting body appropriate to the profession in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under **review or** appeal;

[~~(iii)~~] **(C)** has been practicing in such area of specialty for a period of at least five years;

[~~(iv)~~] **(D) for purposes of a determination involving substance use disorder treatment, specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license,**

certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

(E) for purposes of a determination involving treatment for a mental health condition, specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession;

(F) is knowledgeable about the health care service or treatment under review or appeal; and

[~~(v)~~] (G) where applicable to such health care professional's scope of practice, is clinically supported by a physician who possesses a current and valid non-restricted license to practice medicine; or

[~~(C)~~] (H) for purposes of a determination involving treatment of a medically fragile child:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who is board certified or board eligible in pediatric rehabilitation, pediatric critical care, or neonatology; or

(ii) a physician who possesses a current and valid non-restricted license to practice medicine and is board certified in a pediatric subspecialty directly relevant to the patient's medical condition.

[~~(3)~~] Nothing [~~herein~~] in this subsection shall be construed to change any statutorily-defined scope of practice.

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

PART BBB

Section 1. Short title. This act shall be known and may be cited as the "reproductive freedom and equity grant program".

§ 2. Legislative findings. The legislature finds:

1. Abortion is essential health care and integral to the overall health and wellbeing of individuals.

2. In 1970, New York legalized abortion, three years prior to the Supreme Court decision in Roe v. Wade, which enumerated a constitutional right to abortion care.

3. On January 22, 2019, the 46th anniversary of the Supreme Court decision Roe v. Wade, New York modernized our state law to be consistent with the holdings of Roe v. Wade, articulating in that every individual has a fundamental right to abortion.

4. Despite a state right to abortion care, barriers exist that challenge an individual's ability to exercise their right to care.

5. Individuals seeking abortion care can often experience obstacles to obtaining an abortion, whether that is an inability to afford the cost of care, the distance one must travel, the costs associated with travel including transportation needs, childcare, lodging, lost wages and more.

6. Barriers to care are often intensified for immigrants, young people, people with disabilities and those living in rural areas.

7. The United States Supreme Court overturned Roe v. Wade on June 24, 2022, significantly impacting access to care across the country for millions.

8. It is estimated that in the wake of state bans on abortion across the country, New York would be the nearest provider of care for 190,000 to 280,000 more women of reproductive age.

9. Abortion funds, abortion providers, and other community-based organizations have provided essential support to individuals facing practical support needs. These entities assist individuals seeking abortion care including those living in New York, those traveling to New York and those who must travel outside of New York for care.

10. With no direct and sustained state investment, safety-net abortion providers and abortion funds predominately rely on philanthropic giving to address unmet needs of abortion patients, challenging their ability to meet present need, or any future increase demand for care.

11. New York has a proud legacy of protecting and expanding access to comprehensive reproductive and sexual health care services, including abortion.

12. In furtherance of that legacy, it is incumbent upon the state to adopt bold and innovative programs and policies that protect and advance reproductive freedom.

§ 3. Article 25-A of the public health law is amended by adding a new section 2599-bb-1 to read as follows:

§ 2599-bb-1. Reproductive freedom and equity grant program. 1. As used in this section, the following terms shall have the following meanings:

(a) "Abortion" shall mean the termination of pregnancy pursuant to section twenty-five hundred ninety-nine-bb of this article.

(b) "Medical services" shall mean the range of care related to the provision of abortion.

(c) "Practical support" shall mean direct assistance to enable a person to obtain abortion care, including but not limited to ground and air transportation, gas money, lodging, meals, childcare, translation services, and doula support.

(d) "Program" shall mean the reproductive freedom and equity grant program.

2. There is hereby established in the department a reproductive freedom and equity grant program to ensure access to abortion care in the state. Such program shall provide funding to abortion providers, government entities and non-profit organizations whose primary function is to facilitate access to abortion care. The program is designed to provide support to abortion providers to increase access to care, fund uncompensated care, and to address the support needs of individuals accessing abortion care. The governor shall include an appropriation in the executive budget or identify funding that can be used to support the program.

3. The commissioner is authorized to distribute funds made available for expenditure pursuant to this section. In determining funding for applicants under the grant program, the commissioner shall consider the following criteria and goals:

(a) Increase access to care by growing the capacity of abortion providers to meet present and future care needs. Funds shall be awarded to support the recruitment and retention of staff, patient navigators, staff training, the establishment of new or renovation of existing health centers, investments in technology to facilitate care, security enhancements, and other operational needs that reflect the intention of increasing access to abortion care.

(b) Fund uncompensated care, to ensure the affordability of and access to care for anyone who seeks care in the state, regardless of their ability to pay for care. Funds shall be awarded to abortion providers, government entities and non-profit entities to support uncompensated costs of the medical services associated with abortion care for individ-

uals who lack insurance coverage, are underinsured, or whose insurance is deemed unusable by the rendering provider.

(c) Address practical support needs of individuals accessing abortion care. Funds shall be awarded to non-profit entities providing practical support to individuals within and traveling to the state.

4. In establishing and operating the program, the department shall consult a range of experts including but not limited to individuals and entities providing abortion care, abortion funds and other organizations whose mission is to expand access to abortion care, to ensure the program structure and expenditures are reflective of the needs of abortion providers, abortion funds and consumers. The department shall promulgate regulations necessary for implementation of the program.

5. The department shall not request, promulgate regulations to, or otherwise require, any abortion provider or non-profit organization receiving monies from the program to divulge the name, address, photograph, license number, email address, phone number, or any other personally identifying information of any patient, or individual who sought or received practical support from such provider or organization, in conjunction with the funding provided pursuant to this section.

6. Any non-profit organization or provider receiving funds from the program shall take all necessary steps to ensure the confidentiality of the individuals receiving services pursuant to state and federal laws.

§ 4. Severability clause. 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.

§ 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 CCC

Section 1. Paragraph (g) of subdivision 2 of section 2807 of the public health law is amended by adding a new subparagraph (iii) to read as follows:

(iii) (A) As used in this subparagraph, the following terms shall have the following meanings:

(1) "Child with medical fragility" shall mean an individual who is under twenty-one years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and meets one or more of the following criteria: (I) is technology-dependent for life or health sustaining functions, (II) requires complex medication regimens or medical interventions to maintain or to improve their health status, or (III) is 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.

(2) "Pediatric residential health care facility" shall mean a free-standing facility or discrete unit within a facility authorized by the commissioner to provide extensive nursing, medical, psychological, and counseling support services solely to children.

(3) "Pediatric diagnostic and treatment center" shall mean a diagnostic and treatment center established pursuant to this article that provides services to children with medical fragility and is affiliated with a pediatric residential health care facility.

(B) (1) Notwithstanding any law, rule, or regulation to the contrary, the commissioner shall establish rates of reimbursement for pediatric diagnostic and treatment centers for all services provided on or after April first, two thousand twenty-three, to children eligible for medical assistance that reflect the costs necessary to provide care and services to children with medical fragility being treated at such pediatric diagnostic and treatment center.

(2) For the period April first, two thousand twenty-three, to December thirty-first, two thousand twenty-three, and until such time as a certified annual cost report for such period is received and verified by the department, the operating component of the rate shall reflect budgeted costs for the period January first, two thousand twenty-three, through December thirty-first, two thousand twenty-three, as submitted to the department and adjusted as the commissioner deems appropriate. Upon submission and subsequent verification of the cost report, the operating component of the rate shall reflect actual costs for the period January first, two thousand twenty-three, through December thirty-first, two thousand twenty-three, subject to further adjustments as the commissioner deems appropriate. Thereafter, the base period reported operating costs used to establish rates pursuant to this paragraph shall be updated no less frequently than every two years. In addition to required annual cost reports, pediatric diagnostic and treatment centers shall submit additional data as the commissioner requires.

(3) Notwithstanding any law, rule or regulation to the contrary, pediatric diagnostic and treatment centers shall be reimbursed for services provided to children enrolled in Medicaid managed care plans at the rates of reimbursement promulgated pursuant to item two of this clause.

(4) The capital component of the rate shall reflect actual base year costs.

(5) The commissioner may promulgate or amend regulations as the commissioner determines appropriate and necessary to establish the rates provided for in items two, three, and four of this clause and/or to provide for the exemption of pediatric diagnostic and treatment centers from the ambulatory payment group reimbursement methodology applicable to diagnostic and treatment centers.

§ 2. This act shall take effect April 1, 2023.

PART DDD

Section 1. The public health law is amended by adding a new section 4003 to read as follows:

§ 4003. Director of hospice and palliative care access and quality. 1. The office of hospice and palliative care access and quality is hereby created within the department. The commissioner shall appoint a director of the office and may employ such assistants and personnel as are necessary to carry out the provisions of this article.

2. The office shall have the following powers and duties:

(a) to provide expertise and input on hospice and palliative care policy development and regulation;

(b) to ensure hospice and palliative care providers, workers, and patients are considered when new policy or regulatory changes are contemplated, developed or implemented;

(c) to develop recommendations to improve patient care for individuals with chronic or life-limiting illnesses;

(d) to facilitate communication between the department and hospice and palliative care providers;

(e) to raise awareness and access to hospice and palliative care services;

(f) to identify and eliminate barriers to such services;

(g) to support models of care and service delivery that would assist in increasing utilization of hospice and palliative care services;

(h) to work to develop and promote innovative health care delivery models for hospice and palliative care services;

(i) to establish and monitor quality and utilization metrics to promote increased access to high-quality end-of-life care;

(j) to support community-wide efforts to promote advance care planning;

(k) to work in collaboration with the state palliative care education and training council, centers for palliative care excellence, and palliative care practitioner resource centers, to assist in providing education on hospice and palliative care to state, regional, and local personnel;

(l) to ensure equitable access to hospice and palliative care services by underrepresented communities across New York state.

3. The commissioner, in conjunction with the director appointed pursuant to this section, shall prepare and submit a report to the governor, the temporary president of the senate and the speaker of the assembly, and post such report on the department's website, by no later than two years following the effective date of this act and annually thereafter, outlining the activities of the office established pursuant to this section, and recommendations on matters within the scope of the director's duties as set forth in this section.

§ 2. 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 EEE

Section 1. The commissioner of mental health shall establish a maternal mental health workgroup (referred to in this section as the "workgroup") within the office of mental health. The workgroup shall consist of, at the minimum, the commissioner of mental health or his, her or their designee, the commissioner of the office of children and family services or his, her or their designee; the commissioner of the department of health or his, her or their designee; representatives from statewide mental health organizations; representatives from maternal health care provider organizations; representatives from health care provider organizations; representatives from the health insurance industry; and any additional stakeholders that the commissioners deem necessary. At least one-third of the members shall be from historically underrepresented communities that are disproportionately impacted by the underdiagnoses of maternal mental health disorders.

§ 2. Workgroup members shall receive no compensation for their services as members of the workgroup, but shall be reimbursed for their actual expenses incurred in the performance of their duties on the work group. Reimbursement shall allow for historically underrepresented communities to participate wholly in the performance of their duties on the workgroup by providing, if necessary, reimbursements for reasonable expenses incurred that may include, but not be limited to, childcare, travel, meals and lodging.

§ 3. It shall be the duty of the workgroup to study and issue recommendations related to maternal mental health and perinatal and postpartum mood and anxiety disorders. The workgroup shall:

a. identify underrepresented and vulnerable populations and risk factors in the state for maternal mental health disorders that may occur during pregnancy and through the first postpartum year;

b. identify and recommend effective, culturally competent, and accessible prevention screening and identification and treatment strategies, including public education and workplace awareness, provider education and training, and social support services;

c. identify successful postpartum mental health initiatives in other states and recommend programs, tools, strategies, and funding sources that are needed to implement similar initiatives in the state;

d. identify and recommend evidence-based practices for health care providers and public health systems;

e. identify and recommend private and public funding models;

f. make recommendations on legislation, policy initiatives, funding requirements and budgetary priorities to address maternal mental health needs in the state;

g. any other relevant issues identified by the workgroup; and

h. submit a final report containing all findings and recommendations to the governor, the temporary president of the senate, the speaker of the assembly, the commissioner of mental health, the commissioner of the office of children and family services, the commissioner of the department of health, the minority leader of the senate and the minority leader of the assembly on or before December 31, 2023.

§ 4. This act shall take effect immediately and shall expire two years after such effective date when upon such date the provisions of this act shall be deemed repealed.

PART FFF

Section 1. The public health law is amended by adding a new section 3615-a to read as follows:

§ 3615-a. State aid to certain certified home health agencies and hospice programs. 1. Disparities in health and in access to care provided by certified home health agencies and hospice programs. The commissioner shall make available, subject to appropriations, funds to be used by certified home health agencies and hospice programs to increase certified home health agency and hospice services in areas of the state deemed by the commissioner as underserved or hard to serve.

2. Such funds shall be made available to certified home health agencies and hospices which are determined to be able to service the designated areas, and are eligible and approved by the commissioner pursuant to the provisions of this section.

3. To be considered eligible for receipt of funds pursuant to this section, a certified home health agency or hospice shall submit an

application to the department. Such application shall demonstrate, to the satisfaction of the commissioner, that the agency:

(a) received a certificate of approval pursuant to the provisions of section thirty-six hundred eight of this article or section four thousand eight of this chapter for at least two years prior to the date of the application and that such certificate has not been revoked or annulled subsequent to its receipt and is not limited as of the time of the application;

(b) shall utilize such funds to maintain or increase certified home health agencies and hospice services to persons who seek such services in an area which have been designated by the commissioner as underserved or hard to serve;

(c) shall undertake reasonable efforts to maintain financial support from public and community contributed funding sources; and

(d) demonstrates a longstanding service commitment to the underserved or hard to serve areas for which funds would be applied.

4. The commissioner is authorized to promulgate or adopt any rules or regulations necessary for the implementation this section.

§ 2. This act shall take effect immediately.

PART GGG

Section 1. Subdivision 18 of section 364-j of the social services law is amended by adding a new paragraph (c-1) to read as follows:

(c-1) In setting such reimbursement, the commissioner of health shall establish a quality incentive program for managed care providers that is distributed based on managed care providers' performance in meeting quality objectives, which shall be set by the commissioner in advance of the period during which quality is measured. Such quality incentive program shall be funded at a level of at least one percent of the total annual premium paid to managed care providers, or seventy million dollars, whichever is greater. In establishing the manner in which to measure quality and distribute quality incentive program funds, the commissioner of health shall establish a methodology that provides the greatest level of funding to managed care providers receiving the highest quality scores and shall consult with representatives of managed care providers and other key stakeholders.

§ 2. Subdivision 8 of section 4403-f of the public health law, as amended by section 21 of part B of chapter 59 of the laws of 2016, is amended to read as follows:

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. In setting

such payment rates, the commissioner shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care shall comply with all applicable laws and regulations, state and federal, including regulations as to actuarial soundness for medicaid managed care. **In setting such reimbursement, the commissioner shall establish a quality incentive program for managed long term care plans that shall be distributed based on such plans' performance in meeting quality objectives, which shall be set by the commissioner in advance of the period during which quality is measured. Such quality incentive program shall be funded at a level of at least one percent of the total annual premium paid to managed long term care plans. In establishing the manner in which to measure quality and distribute quality incentive program funds, the commissioner shall establish a methodology that provides the greatest level of funding to managed long term care plans receiving the highest quality scores and shall consult with representatives of managed long term care plans and other key stakeholders.**

§ 3. This act shall take effect on the first of January next succeeding the date upon which it shall have become a law; provided, however, that the amendments to section 364-j of the social services law and section 4403-f of the public health law made by sections one and two of this act shall not affect the repeal of such sections and shall be deemed repealed therewith.

PART HHH

Section 1. The office of mental health, in collaboration with the office of addiction services and supports, shall establish the Daniel's Law task force, consisting of individuals with expertise in non-police, trauma-informed, community-led responses to mental health, alcohol use or substance use crises, as well as individuals affected by police responses to mental health, alcohol use or substance use crises.

(a) The Daniel's Law task force shall consist of the following members, or their designees: (1) the commissioner of mental health; and (2) the commissioner of addiction services and supports. Additional members of the task force shall include, but not be limited to: physicians, nurses, and other healthcare professionals with experience researching, diagnosing or treating mental health, alcohol use, or substance use; individuals with lived mental health and/or alcohol use or substance use disorder experience, who have experience navigating systems such as the healthcare, mental health, judicial, criminal justice, housing, education, and employment systems; individuals with lived experience as the primary caregiver of children/youth with social, emotional, behavioral, mental health or alcohol use or substance use disorders, who have experience navigating systems such as the healthcare, mental health, judicial, criminal justice, housing, education, and employment systems; licensed mental health or addiction clinicians; licensed mental health or addiction counselors; crisis healthcare workers; 988 personnel; emergency medical technicians and paramedics; non-governmental organizations that may come into contact with individuals experiencing mental health, alcohol use or substance use crises; and representatives of not-for-profit disability justice organizations.

(b) The Daniel's Law task force's focus shall include, but not be limited to: identifying potential operational and financial needs to support a non-police, trauma-informed, community and public health-based response for anyone in the state experiencing a mental health, alcohol

use, or substance use crisis; reviewing and recommending programs and systems operating within the state or nationally that could be deployed in the entire state as a model crisis and emergency services system; and identifying potential funding sources for expanding preexisting mental health, alcohol use and substance use crisis response services.

(c) The Daniel's Law task force shall convene no later than one hundred twenty days following the effective date of this section and meet as frequently as its business may require, but it shall host at least five statewide town halls, as well as one virtual town hall, prior to and during the implementation of the pilot program to solicit community feedback.

(d) The Daniel's Law task force shall receive no compensation for their participation but shall be reimbursed for expenses actually and necessarily incurred in the performance of their duties.

(e) The office of mental health shall prepare a written report summarizing opinions and recommendations from the Daniel's Law task force which includes a list of existing, publicly accessible mental health, alcohol use, and substance use crisis response services. The report shall examine the effectiveness of the pilot program established pursuant to this act in addressing non-police, trauma-informed, community-led responses to mental health, alcohol use or substance use crises.

(f) This report shall be submitted to the governor, speaker of the assembly and temporary president of the senate no later than December 31, 2025 and shall be posted on the office of mental health's website.

(g) The office of mental health in consultation with the Daniel's Law task force, shall establish the Daniel's Law pilot program for non-police, trauma-informed, community-led responses to mental health, alcohol use or substance use crises. Awards shall be available to community-based public health-based response programs that utilize crisis response teams for anyone experiencing a mental health, alcohol use or substance use crisis administered by community-based organizations, not-for-profits and/or local governments. The crisis response teams shall comply with the following parameters: (a) the crisis response teams shall receive culturally competent, trauma-informed, training; (b) the crisis response teams shall de-escalate any situation involving individuals experiencing a crisis due to mental health conditions, alcohol use, or substance use and avoid the use of nonconsensual treatment, transport, or force wherever possible; (c) the crisis response teams shall provide the most appropriate treatment to individuals experiencing a mental health, alcohol use or substance use crisis; (d) voluntary assessment and referral of individuals experiencing a mental health, alcohol use or substance use crisis shall be maximized; and (e) the crisis response teams shall effectively respond to all individuals experiencing a mental health, alcohol use or substance use crisis with culturally competent, trauma-informed care. Priority shall be given to programs that involve law enforcement only as a last resort while providing crisis intervention services.

§ 2. This act shall take effect immediately provided, however, that the provisions of section one of this act shall expire and be deemed repealed April 1, 2025.

§ 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 judg-

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