A3007-B Budget No Same as
Budget Article VII (Internal # 8 - 2021)
Budget Bills
TITLE....Enacts into law major components of legislation necessary to implement the state health and mental hygiene budget for the 2021-2022 state fiscal year
01/20/21 referred to ways and means
02/24/21 amend (t) and recommit to ways and means
02/24/21 print number 3007a
03/13/21 amend (t) and recommit to ways and means
03/13/21 print number 3007b

STATE OF NEW YORK

3007--B

IN ASSEMBLY

January 20, 2021

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

AN ACT to 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); intentionally omitted (Part B); to amend part FFF of chapter 56 of the laws of 2020, amending the public health law relating to extending and enhancing the Medicaid drug cap and to reduce unnecessary pharmacy benefit manager costs to the Medicaid program, in relation to temporarily exempting covered entities under the federal 340B program and comprehensive HIV special needs plans (Part C); intentionally omitted (Part D); intentionally omitted (Part E); to amend the public health law in relation to the definition of originating sites in regards to telehealth services (Part F); to amend the public health law, in relation to authorizing the implementation of medical respite pilot programs (Part G); to amend the social services law, in relation to eliminating consumer-paid premium payments in the basic health program; and providing for the repeal of certain provisions of such law upon expiration thereof (Part H); intentionally omitted (Part I); intentionally omitted (Part J); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending the physicians medical malpractice program; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part K); intentionally omitted

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

LBD12571-03-1

(Part L); intentionally omitted (Part M); intentionally omitted (Part N); intentionally omitted (Part O); intentionally omitted (Part P); intentionally omitted (Part Q); intentionally omitted (Part R); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend chapter 517 of the laws of 2016, amending the public health law relating to payments from the New York state medical indemnity fund, in relation to the effectiveness thereof; to amend the public health law, in relation to improved integration of health care and financing; to amend chapter 56 of the laws of 2014, amending the education law relating to the nurse practitioners modernization act, in relation to extending the provisions thereof; and to amend chapter 66 of the laws of 2016, amending the public health law relating to reporting of opioid overdose data, in relation to the effectiveness thereof (Part S); to amend part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part T); intentionally omitted (Part U); to amend part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs in relation to the effectiveness thereof; and to amend the mental hygiene law, in relation to requiring certain evaluations, assessments and recommendations to be included in the commissioners statewide comprehensive plan (Part V); to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to extending such provisions relating thereto; and to amend the mental hygiene law, in relation to the appropriation of funds for the community mental health support and workforce reinvestment program (Part W); intentionally omitted (Part X); intentionally omitted (Part Y); to amend the mental hygiene law, in relation to imposing sanctions due to a provider's failure to comply with the terms of their operating certificate or applicable law and to charge an application processing fee for the issuance of operating certificates (Part Z); to amend the mental hygiene law and the social services law, in relation to crisis stabilization services (Subpart A); intentionally omitted (Subpart B); intentionally omitted (Subpart C) (Part AA); intentionally omitted (Part BB); intentionally omitted (Part CC); intentionally omitted (Part DD); intentionally omitted (Part EE); intentionally omitted (Part FF); intentionally

omitted (Part GG); intentionally omitted (Part HH); to amend the social services law, in relation to the provision of services to certain persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services (Part II); to amend the social services law, in relation to school-based health centers for purposes of managed care programs under medicaid (Part JJ); to amend the social services law, in relation to extending the Medicaid coverage period for pregnancy (Part KK); to amend the public health law, in relation to the adult cystic fibrosis assistance program (Part LL); in relation to requiring the commissioner of health to review rates of reimbursement made through the Medicaid program for ambulette transportation for rate adequacy (Part MM); to amend the public health law, in relation to requiring the commissioner of health to review the rates of reimbursement and adequacy of the early intervention program (Part NN); to amend chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, in relation to the effectiveness thereof (Part OO); to amend the public health law, in relation to prohibiting program-wide service limitations (Part PP); to amend the social services law, in relation to eligibility for medical assistance (Part QQ); to amend the mental hygiene law, in relation to suicide prevention for high risk groups (Part RR); to amend the mental hygiene law, in relation to suicide prevention for law enforcement, veterans, first responders, and correction officers (Part SS); to amend the public health law, in relation to funds for the New York state area health education center program for certain programs (Part TT); to amend part C of chapter 57 of the laws of 2006 relating to establishing a cost of living adjustment for designated human services programs, in relation to extending COLA provisions for the purpose of establishing rates of payments and in relation to the effectiveness thereof (Part UU); to amend the public health law, in relation to funding early intervention services; and to repeal certain provisions of the public health law and the insurance law relating thereto (Part VV); to amend part KKK of chapter 56 of the laws of 2020 amending the social services law and other laws relating to managed care encounter data, authorizing electronic notifications, and establishing regional demonstration projects, in relation to the regional demonstration program (Part WW); and to amend the public health law and the insurance law, in relation to enhancing coverage and care for medically fragile children (Part XX)

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

Section 1. This act enacts into law major components of legislation necessary to implement the state health and mental hygiene budget for the 2021-2022 state fiscal year. Each component is wholly contained within a Part identified as Parts A through XX. 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

Intentionally Omitted

PART C

Section 1. Part FFF of chapter 56 of the laws of 2020, amending the public health law relating to extending and enhancing the Medicaid drug cap and to reduce unnecessary pharmacy benefit manager costs to the Medicaid program, is amended by adding a new section 1-b to read as follows:

§ 1-b. Notwithstanding any provision of this part or other law, no action shall be taken by the commissioner of health or the department of health to remove the pharmacy benefit from the managed care benefit package under medical assistance (Medicaid) before April 1, 2024 for the following entities: (a) an eligible provider under section 340B of the federal Public Health Service Act and (b) a comprehensive HIV special needs plan under section 4403-c of the public health law.

§ 2. This act shall take effect immediately.

PART D

Intentionally Omitted

PART E

Intentionally Omitted

PART F

Section 1. Subdivision 3 of section 2999-cc of the public health law, as amended by section 2 of subpart C of part S of chapter 57 of the laws of 2018, is amended to read as follows:

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

§ 2. Intentionally omitted.

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

PART G

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

ARTICLE 29-J
MEDICAL RESPITE PROGRAM

Section 2999-hh. Medical respite program.

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

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

(i) Temporary room and board with appropriate kitchen and bathroom facilities for the recipient, and where applicable, family members and/or dependents; and

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

(b) "Recipient" means an individual who:

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

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

(iii) Is experiencing homelessness or at imminent risk of homelessness. A person shall be deemed "homeless" if they lack a fixed, regular and adequate nighttime residence in a location ordinarily used as a regular sleeping accommodation for people.

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

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

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

(i) Provide recipients and where applicable, their family members with temporary room and board with appropriate kitchen and bathroom facilities; and

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

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

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

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

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

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

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

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

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

PART H

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

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

§ 2. Paragraph (d) of subdivision 3, subdivision 5 and subdivision 7 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014 and subdivision 7 as renumbered by section 28 of part B of chapter 57 of the laws of 2015, are amended to read as follows:

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

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

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

~~(i) up to twenty dollars monthly for an individual with a household income above one hundred and fifty percent of the federal poverty line but at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and~~

~~(ii) no~~] No payment is required for individuals with a household income at or below [~~one hundred and fifty~~] two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size.

(b) [~~The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval~~] There shall be no cost sharing obligations for enrollees, including for dental and vision services.

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

meet the requirements of applicable federal and state laws and regulations.

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

3-a. Novel coronavirus, COVID-19 eligibility. A person shall also be eligible to receive coverage for health care services under this title, without regard to federal financial participation, if he or she is a resident of the state, has or has had a confirmed or suspected case of novel coronavirus, COVID-19, household income below two hundred percent of the federal poverty line as defined and annually revised by the United States department of health and human services for a household of the same size, and is ineligible for federal financial participation in the basic health program under 42 U.S.C. section 18051 on the basis of immigration status, but otherwise meets the eligibility requirements in paragraphs (b) and (c) of subdivision three of this section. An applicant who fails to make an applicable premium payment shall lose eligibility to receive coverage for health care services in accordance with the time frames and procedures determined by the commissioner.

§ 3. This act shall take effect immediately; provided, however, that sections one and two of this act shall take effect June 1, 2021; provided further, however, that section two-a of this act shall expire and be deemed repealed sixty days following the conclusion of the state disaster emergency declared pursuant to executive order 202, provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the conclusion of such executive order in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART I

Intentionally Omitted

PART J

Intentionally Omitted

PART K

Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part AAA of chapter 56 of the laws of 2020, is amended to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of

the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, [~~and~~] between July 1, 2020 and June 30, 2021**, and between July 1, 2021 and June 30, 2022** or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, [~~and~~] between July 1, 2020 and June 30, 2021**, and between July 1, 2021 and June 30, 2022** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a

hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part AAA of chapter 56 of the laws of 2020, is amended to read as follows:

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

[~~and~~] between July 1, 2020 and June 30, 2021**, and between July 1, 2021 and June 30, 2022** allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

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

2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, to the period July 1, 2016 and June 30, 2017, to the period July 1, 2017 to June 30, 2018, to the period July 1, 2018 to June 30, 2019, to the period July 1, 2019 to June 30, 2020, [~~and~~] to the period July 1, 2020 to June 30, 2021**, and to the period July 1, 2021 to June 30, 2022**.

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part AAA of chapter 56 of the laws of 2020, are amended to read as follows:

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

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021**, or covering the period July 1, 2021 to June 30, 2022** shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering

the period July 1, 2020 to June 30, 2021**, or covering the period July 1, 2021 to June 30, 2022** determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

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

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

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

§ 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part AAA of chapter 56 of the laws of 2020, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [~~2021~~] **2022**; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is

attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [~~2021~~] **2022**, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [~~2021~~] **2022** policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 6 of part AAA of chapter 56 of the laws of 2020, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June

15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, [~~and~~] June 15, 2021**, and June 15, 2022** the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021**, or July 1, 2021 to June 30, 2022** as applicable.

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

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

§ 6. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 7 of part AAA of chapter 56 of the laws of 2020, is amended to read as follows:

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

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

PART L

Intentionally Omitted

PART M

Intentionally Omitted

PART N

Intentionally Omitted

PART O

Intentionally Omitted

PART P

Intentionally Omitted

PART Q

Intentionally Omitted

PART R

Intentionally Omitted

PART S

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

§ 11. This act shall take effect immediately and:

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

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

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

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

(a) sections two, three, three-a, three-b, three-c, three-d, three-e and twenty-one of this act shall take effect July 1, 2010; sections fifteen, sixteen, seventeen, eighteen and nineteen of this act shall take effect January 1, 2011; and provided further that section twenty of this act shall be deemed repealed [~~ten~~] twelve years after the date the contract entered into pursuant to section 365-h of the social services law, as amended by section twenty of this act, is executed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the execution of the contract entered into pursuant to section 367-h of the social services law in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law;

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

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2022;

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

§ 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021**, and on and after April 1, 2021 through March 31, 2022**.

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

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

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

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000

through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, 2015 and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2022;

§ 7. Intentionally omitted.

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

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

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

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

§ 10. Section 3 of part D of chapter 56 of the laws of 2014, amending the education law relating to the nurse practitioners modernization act, is amended to read as follows:

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

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

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

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

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

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

PART T

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

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

§ 2. This act shall take effect immediately.

PART U

Intentionally Omitted

PART V

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

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

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

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

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

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

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

h. include quarterly evaluations, assessments, and recommendations for time limited demonstration programs pursuant to subdivision (d) of section 41.53 of this chapter.

§ 2. This act shall take effect immediately.

PART W

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

1 of part V of chapter 57 of the laws of 2018, is amended to read as
2 follows:
3 § 7. This act shall take effect immediately and shall expire March 31,
4 [~~2021~~] 2024 when upon such date the provisions of this act shall be
5 deemed repealed.
6 § 1-a. Subdivision (h) of section 41.55 of the mental hygiene law, as
7 added by section 2 of part R2 of chapter 62 of the laws of 2003 and as
8 relettered by section 4 of part C of chapter 111 of the laws of 2010, is
9 amended to read as follows:
10 (h) Amounts made available to the community mental health support and
11 workforce reinvestment program of the office of mental health shall be
12 subject to annual appropriations therefor[~~. Up~~]:
13 (1) up to fifteen percent of the amounts so appropriated shall be made
14 available for staffing at state mental health facilities;
15 (2) no less than twenty percent of the amounts so appropriated shall
16 be made available for workforce recruitment and retention at mental
17 health programs certified under article thirty-one of this chapter; and
18 (3) at least seven percent of the remaining funds may be allocated for
19 state operated community services pursuant to this section.
20 § 2. This act shall take effect immediately, provided, however, that
21 the amendments to subdivision (h) of section 41.55 of the mental hygiene
22 law made by section one-a of this act shall not affect the repeal of
23 such section and shall be deemed to be repealed therewith.

24 PART X

25 Intentionally Omitted

26 PART Y

27 Intentionally Omitted

28 PART Z

29 Section 1. Intentionally omitted.
30 § 2. Subdivision (a) of section 31.04 of the mental hygiene law is
31 amended by adding a new paragraph 8 to read as follows:
32 8. establishing a schedule of fees for the purpose of processing
33 applications for the issuance of operating certificates. All fees pursu-
34 ant to this section shall be payable to the mental illness anti-stigma
35 fund under section 95-h of the state finance law.
36 § 3. This act shall take effect on the one hundred eightieth day
37 after it shall have become a law. Effective immediately, the commis-
38 sioner of mental health is authorized to promulgate any and all rules
39 and regulations and take any other measures necessary to implement this
40 act on its effective date or before such date.

41 PART AA

42 Section 1. This Part enacts into law legislation relating to crisis
43 stabilization services, Kendra's law and assisted outpatient treatment
44 and involuntary commitment. Each component is wholly contained within a
45 Subpart identified as Subparts A through C. The effective date for each
46 particular provision contained within each Subpart is set forth in the
47 last section of such Subpart. Any provision in any section contained
48 within a Subpart, including the effective date of the Subpart, which

makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Subpart in which it is found. Section three of this Part sets forth the general effective date of this Part.

SUBPART A

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

§ 31.36 Crisis stabilization services.

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

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

§ 32.36 Crisis stabilization services.

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

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

ARTICLE XXXVI

ADDICTION AND MENTAL HEALTH SERVICES AND SUPPORTS

§ 36.01 Crisis stabilization centers.

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

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

(i) Engagement, triage and assessment;

(ii) Continuous observation;

(iii) Mild to moderate detoxification;

(iv) Sobering services;

(v) Therapeutic interventions;

(vi) Discharge and after care planning;

(vii) Telemedicine;

(viii) Peer support services; and

(ix) Medication assisted treatment.

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

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

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

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

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

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

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

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

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

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

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

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

(b) Each crisis stabilization center shall be staffed with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community which shall include, but not be limited to, at least one psychiatrist or psychiatric nurse practitioner, a credentialed alcoholism and substance abuse counselor and one peer support specialist on duty and available at all times, provided, however, the commissioners may promulgate regulations to permit the issuance of a waiver of this requirement when the volume of service of a center does not require such level of staff coverage. A waiver may be issued to a crisis stabilization center, which has been established prior to the effective date of this article, that has demonstrated the ability to effectively operate crisis stabilization centers under an effective model of care which may be replicated throughout the state.

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

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

(e) The commissioners shall develop or use existing educational materials and provide the materials to crisis stabilization centers who shall disseminate them to local practitioners, community mental health and substance use programs, hospitals, law enforcement, the local judicial system, and peers. The materials shall include appropriate education relating to de-escalation techniques, cultural competency, the

recovery process, mental health, substance use, and avoidance of aggressive confrontation.

(f) Within the amounts appropriated, the commissioners shall ensure that the appropriate training is provided to each law enforcement entity, first responders, and any other entities deemed appropriate by the commissioners, located within the catchment area of a crisis stabilization center. The training shall include but not be limited to: (1) crisis intervention team training; (2) mental health first aid; and (3) implicit bias training. Such training may be provided in an electronic format or other format as deemed appropriate by the commissioners. The commissioners shall contract with an organization with the knowledge and expertise in providing the training required under this subdivision.

§ 36.02 Referral to crisis stabilization centers.

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

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

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

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

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

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

(b) As an alternative to an emergency admission, a person otherwise determined to meet the criteria for an emergency admission pursuant to

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

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

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

(a) Whenever any court of inferior or general jurisdiction is informed by verified statement that a person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to result in serious harm to himself or herself, such court shall issue a warrant directing that such person be brought before it. If, when said person is brought before the court, it appears to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm to himself or herself or others, the court shall issue a civil order directing his or her removal to any hospital specified in subdivision (a) of section 9.39 of this article or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40 of this article, that is willing to receive such person for a determination by the director of such hospital or program whether such person should be [~~retained~~] received therein pursuant to such section.

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

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

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

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

(a) The director of community services or the director's designee shall have the power to direct the removal of any person, within his or her jurisdiction, to a hospital approved by the commissioner pursuant to subdivision (a) of section 9.39 of this article, or to a comprehensive psychiatric emergency program pursuant to subdivision (a) of section 9.40 of this article, if the parent, adult sibling, spouse or child of the person, the committee or legal guardian of the person, a licensed psychologist, registered professional nurse or certified social worker currently responsible for providing treatment services to the person, a supportive or intensive case manager currently assigned to the person by a case management program which program is approved by the office of

mental health for the purpose of reporting under this section, a licensed physician, health officer, peace officer or police officer reports to him or her that such person has a mental illness for which immediate care and treatment [~~in a hospital~~] is appropriate and which is likely to result in serious harm to himself or herself or others. It shall be the duty of peace officers, when acting pursuant to their special duties, or police officers, who are members of an authorized police department or force or of a sheriff's department to assist representatives of such director to take into custody and transport any such person. Upon the request of a director of community services or the director's designee an ambulance service, as defined in subdivision two of section three thousand one of the public health law, is authorized to transport any such person. Such person may then be retained in a hospital pursuant to the provisions of section 9.39 of this article or in a comprehensive psychiatric emergency program pursuant to the provisions of section 9.40 of this article.

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

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

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

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

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

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

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

5. "Treatment facility" means a facility designated by the commissioner which may only include a general hospital as defined in article twenty-eight of the public health law, or a medically managed or medically supervised withdrawal, inpatient rehabilitation, or residential stabilization treatment program that has been certified by the commissioner to have appropriate medical staff available on-site at all times to provide

emergency services and continued evaluation of capacity of individuals retained under this section **or a crisis stabilization center licensed pursuant to article 36.01 of this chapter**.

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

§ 11. This act shall take effect October 1, 2021; provided, however, that the amendments to sections 9.41, 9.43 and 9.45 of the mental hygiene law made by sections four, five and six of this act shall not affect the expiration of such sections and shall expire therewith. 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 B

Intentionally Omitted

SUBPART C

Intentionally Omitted

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

PART BB

Intentionally Omitted

PART CC

Intentionally Omitted

PART DD

Intentionally Omitted

PART EE

Intentionally Omitted

PART FF

Intentionally Omitted

PART GG

Intentionally Omitted

PART HH

Intentionally Omitted

PART II

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

(d-2) Services provided pursuant to waivers, granted pursuant to subsection (c) of section 1915 of the federal social security act, to persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services, shall not be provided to medical assistance recipients through managed care programs [~~until at least January first, two thousand twenty-two~~] established pursuant to this section; provided, further that the commissioner of health is hereby directed to take any action required, including but not limited to filing waivers and waiver extensions as necessary with the federal government, to continue the provision of such services.

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

PART JJ

Section 1. Subdivision 1 of section 364-j of the social services law is amended by adding two new paragraphs (w) and (w-1) to read as follows:

(w) "School-based health center". A clinic licensed under article twenty-eight of the public health law or sponsored either fully or partially by a facility licensed under article twenty-eight of the public health law or where such sponsorship is dually shared with a facility licensed under article thirty-one of the mental hygiene law which provides primary and preventive care which may include but is not limited to health maintenance, well-child care, diagnosis and treatment of injury and acute illness, diagnosis and management of chronic disease, behavioral services, vision care, dental care, and nutritional or other enhanced services to children and adolescents, any of which may be provided by referral, within an elementary, secondary or prekindergarten public school setting.

(w-1) "Sponsoring organization". A facility licensed under article twenty-eight of the public health law which acts as the sponsor for a school-based health center, which such sponsorship may be dually shared with a facility licensed under article thirty-one of the mental hygiene law.

§ 2. Section 364-j of the social services law is amended by adding a new subdivision 4-a to read as follows:

4-a. (a) Medical assistance services and supplies provided by a school-based health center may be provided and paid for other than by a managed care provider. In such case, the services and supplies shall be

paid in accordance with applicable reimbursement methodologies, which shall mean:

(i) for a school-based health center that is sponsored by a federally qualified health center, rates of reimbursement and requirements in accordance with those mandated by 42 U.S.C. Secs. 1396a(bb), 1396b(m)(2)(A)(ix) and 1396a(a)(13)(C); and

(ii) for a school-based health center that is sponsored by an entity licensed pursuant to article twenty-eight of the public health law that is not a federally qualified health center or is a federally qualified health center that chooses not to receive reimbursement pursuant to subparagraph (i) of this paragraph, rates of reimbursement at the fee for service rate for such services and supplies in effect on the effective date of this subparagraph for the ambulatory patient group rate for the applicable service and supply and in accordance with any future adjustments made to such rates by the department of health.

(b) This subdivision shall not preclude a school-based health center or sponsoring organization from choosing to provide medical assistance services and supplies through managed care providers.

(c) This paragraph applies where a managed care provider includes as an enrollee a student who is eligible to be served by a school-based health center, regardless of whether the school-based health center or sponsoring organization chooses to provide medical assistance services and supplies through the managed care provider. The school-based health center or sponsoring organization and the managed care provider shall enter into a standard memorandum of understanding, which shall be developed by the commissioner for the purpose of promoting the delivery of coordinated health care and participation in quality improvement initiatives. The commissioner shall periodically share enrollment, encounter, and any other data the commissioner determines necessary with each enrolled participant's medicaid managed care provider to allow the exchange of such data between medicaid managed care providers and school-based health centers for the purpose of this paragraph and facilitating enrollee access to services and improving coordination and quality of care.

§ 3. This act shall take effect on the one hundred eightieth day after it shall have become a law; provided that the amendments to section 364-j of the social services law made by sections one and two of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith. Effective immediately, the commissioner of health shall make regulations and take other actions reasonably necessary to implement this act on its effective date.

PART KK

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

(3) cooperates with the appropriate social services official or the department in establishing paternity or in establishing, modifying, or enforcing a support order with respect to his or her child; provided, however, that nothing herein contained shall be construed to require a payment under this title for care or services, the cost of which may be met in whole or in part by a third party; notwithstanding the foregoing, a social services official shall not require such cooperation if the social services official or the department determines that such actions would be detrimental to the best interest of the child, applicant, or

recipient, or with respect to pregnant women during pregnancy and during the [~~sixty-day~~] one year period beginning on the last day of pregnancy, in accordance with procedures and criteria established by regulations of the department consistent with federal law; and

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

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

§ 3. This act shall take effect on the one hundred eightieth day after it shall have become a law. The commissioner of health shall immediately take all steps necessary and shall use best efforts to secure federal financial participation for eligible beneficiaries under title XIX of the social security act, for the purposes of this act, including the prompt submission of appropriate amendments to the title XIX state plan.

PART LL

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

ARTICLE 27-G

ADULT CYSTIC FIBROSIS ASSISTANCE PROGRAM

Section 2795. Adult cystic fibrosis assistance program.

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

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

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

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

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

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

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

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

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

5. The commissioner shall authorize payment for services related to the care and treatment of cystic fibrosis not otherwise covered by a

health insurance policy. Providers of such services shall be reimbursed at the same rate and claims for payment shall be made as if such individual was eligible for benefits pursuant to title eleven of article five of the social services law.

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

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

§ 2. This act shall take effect immediately.

PART MM

Section 1. Ambulette transportation rate adequacy review. The commissioner of health shall review the rates of reimbursement made through the Medicaid program for ambulette transportation for rate adequacy. By December 31, 2021, the commissioner of health shall report such findings of the rate adequacy review to the temporary president of the senate and the speaker of the assembly.

§ 2. This act shall take effect immediately.

PART NN

Section 1. The public health law is amended by adding a new section 2559-c to read as follows:

§ 2559-c. Early intervention rate adequacy review. 1. The commissioner shall review the rates of reimbursement made through the early intervention program for rate adequacy. The review shall include:

(a) comprehensive assessment of the existing methodology used to determine payment for early intervention screenings, evaluations, services and service coordination, including but not limited to:

(i) Analysis of early intervention rules, regulations, and policies, including policies, processes, and revenue sources;

(ii) Analysis of costs to providers of participating in the early intervention program, including time and cost of travel, service provision, and administrative activities;

(iii) Analysis by discipline and labor region of salary levels for individuals providing early intervention services compared to the salary levels for individuals in the same disciplines and labor regions providing services other than in the early intervention program.

(b) recommendations for maintaining or changing reimbursement methodologies. Recommendations under this paragraph shall be consistent with federal law and shall include recommendations for appropriate changes in state law and regulations. The recommendations shall consider appropriate payment methodologies and rates for in-person and telehealth early intervention evaluations and services to address barriers in timely service provision, as well as racial and socioeconomic disparities in access, with consideration of factors including, but not limited to, payment for bilingual services, travel time, geographic variability, access to and cost of technology, cost of living, and other barriers to timely service provision.

(c) the projected number of children who will need early intervention services in the next five years disaggregated by county.

(d) the workforce needed to provide services in the next five years to all children eligible for early intervention services, disaggregated by county.

(e) opportunities for stakeholder input on current rate methodologies.

2. Within one year after the effective date of this section, the commissioner shall submit a report of the findings and recommendations under this section to the governor, the temporary president of the senate, the speaker of the assembly, and the chairs of the senate and assembly committees on health, and shall post the report on the department's website.

§ 2. This act shall take effect immediately.

PART OO

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

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

§ 2. This act shall take effect immediately; provided, however, that the amendments to part BB of chapter 56 of the laws of 2020 made by section one of this act shall not affect the expiration and repeal of such part and shall be deemed to expire and repeal therewith.

PART PP

Section 1. The public health law is amended by adding a new section 2559-c to read as follows:

§ 2559-c. Blanket service limits prohibited. The commissioner shall not impose predetermined limitations, including limitations on the length, duration, frequency, intensity, method of delivery, group size, or staff ratios, on authorized services under this title. The commissioner shall not impose program-wide service limitations that restrict the ability of an IFSP team to create an individualized plan of early intervention services most appropriate to accommodate the needs of each child and family.

§ 2. This act shall take effect immediately.

PART QQ

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

14. The commissioner of health may make any available amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or, if an amendment is not possible, develop and submit an application for any waiver or approval under the federal social security act that may be necessary to disregard or exempt an amount of income, for the purpose of assisting with housing costs, for individuals receiving coverage of nursing facility services

under this title, other than short-term rehabilitation services, and for individuals in receipt of medical assistance while in an adult home, as defined in subdivision twenty-five of section two of this chapter, who[~~:~~] are **either** (i) discharged to the community[~~,~~] and [~~(ii)~~] if eligible, enrolled in a plan certified pursuant to section forty-four hundred three-f of the public health law **or (ii) discharged to the community and upon discharge will receive personal care or consumer-directed personal assistance services based on a determination that they are in immediate need of such services under subdivision twelve of section three hundred sixty-six-a of this title**; and (iii) do not meet the criteria to be considered an "institutionalized spouse" for purposes of section three hundred sixty-six-c of this title.

§ 2. This act shall take effect immediately.

PART RR

Section 1. Subdivision (g) of section 7.07 of the mental hygiene law, as amended by chapter 626 of the laws of 2019, is amended to read as follows:

(g) **1.** The office of mental health shall have the responsibility for assuring the development of plans, programs, and services in the areas of research and prevention of suicide, to reduce suicidal behavior and suicide through consultation, training, implementation of evidence-based practices, and use of suicide surveillance data. Such plans, programs, and services shall consider the unique needs of differing demographic groups and the impact of gender, race and ethnicity, and cultural and language needs. Such plans, programs, and services shall be developed in cooperation with other agencies and departments of the state, local governments, community organizations and entities, or other organizations and individuals. The office shall prepare and submit a written report to the governor, the speaker of the assembly, and temporary president of the senate that sets forth the progress of the office in the development of such plans, programs, and services by December first, two thousand nineteen, and biennially thereafter. In addition to delineating the progress the office has made, such report shall also include information on specific suicide prevention services and program initiatives developed and implemented to address the needs of high risk minority groups or special populations, including but not limited to latina and latino adolescents, black youth, individuals residing in rural communities, veterans, members of the lesbian, gay, bisexual and transgender community, and any other group deemed high risk or underserved by the office.

2. (a) Within amounts appropriated, the office shall establish a suicide prevention program which shall provide grants to organizations engaged in activities which provide culturally competent suicide prevention services to high-risk populations. The program shall be administered by the office in cooperation with other state agencies necessary for the operation of the program as determined by the commissioner.

(b) For the purposes of this subdivision "high-risk population" shall include Latina adolescents, black youth, members of the lesbian, gay, bi-sexual, transgender, and queer community, and rural communities.

3. (a) The commissioner shall issue a request for proposals and establish criteria to determine the eligibility of applicants for the grants authorized herein. The commissioner shall receive on appropriate forms, information necessary and relevant in establishing eligibility, as

determined by the commissioner. The application, shall at a minimum include: (i) projected goals and outcomes of the program; (ii) range and type of services offered; (iii) community partnerships with local organizations or public institutions, for the purpose of facilitating prevention and treatment referral services in community based settings; (iv) methods and strategies to develop culturally and linguistically competent programs, reduce barriers and promote access to prevention and treatment services for high-risk populations; and (v) the overall operating costs of the program.

(b) Grants shall be awarded no later than September first, two thousand twenty-one. Upon approval of each grant, the commissioner shall contract with each grantee for a period of time not to exceed one year, but may extend the contract for additional one year periods when appropriate.

4. The commissioner may consider applicants that have established effective suicide prevention programs for high-risk populations and that may be expanded in other geographic areas of the state which are in need of suicide prevention services for high-risk populations, provided however, preference may be given to requests for proposals which identify local communities with a high prevalence of death by suicide or suicide attempts for one or more high-risk populations and have a demonstrated need for suicide prevention services.

5. The commissioner shall provide a summary of each grantee's suicide prevention program and its fulfillment of the criteria under subparagraph (a) of paragraph three of this subdivision and include this summary in the report required under this paragraph.

§ 2. This act shall take effect take effect on April 1, 2021.

PART SS

Section 1. Subdivision (g) of section 7.07 of the mental hygiene law, as amended by chapter 626 of the laws of 2019, is amended to read as follows:

(g) (1) (A) (i) Within amounts appropriated, the office of mental health shall establish a suicide prevention program which shall provide grants to organizations engaged in activities which provide culturally competent suicide prevention services to high-risk populations. Such program shall be administered by the office in cooperation with other state agencies necessary for the operation of the program as determined by the commissioner.

(ii) For the purposes of this paragraph "high-risk population" shall include law enforcement, veterans, first responders, and correction officers.

(B) (i) The commissioner shall issue a request for proposals and establish criteria to determine the eligibility of applicants for the grants authorized herein. The commissioner shall receive on appropriate forms, information necessary and relevant in establishing eligibility, as determined by the commissioner. The application shall include, but not be limited to: (a) projected goals and outcomes of the program; (b) range and type of services offered; (c) community partnerships with local organizations or public institutions, for the purpose of facilitating prevention and treatment referral services in community based settings; (d) methods and strategies to develop culturally and linguistically competent programs, reduce barriers and promote access to prevention and treatment services for high-risk populations; and (e) the overall operating costs of the program.

(ii) Grants shall be awarded no later than September first, two thousand twenty-one. Upon approval of each grant, the commissioner shall contract with each grantee for a period of time not to exceed one year, but may extend the contract for one year periods when appropriate.

(C) The commissioner may consider applicants that have established effective suicide prevention programs for high-risk populations and that may be expanded in other geographic areas of the state which are in need of suicide prevention services for high-risk populations, provided however, preference may be given to requests for proposals which identify local communities with a high prevalence of death by suicide or suicide attempts for one or more high-risk populations and have a demonstrated need for suicide prevention services.

(D) The commissioner shall provide a summary of each grantee's suicide prevention program and its fulfillment of the criteria under clause (i) of subparagraph (B) of this paragraph and include this summary in the report required under paragraph two of this subdivision.

(2) The office of mental health shall have the responsibility for assuring the development of plans, programs, and services in the areas of research and prevention of suicide, to reduce suicidal behavior and suicide through consultation, training, implementation of evidence-based practices, and use of suicide surveillance data. Such plans, programs, and services shall consider the unique needs of differing demographic groups and the impact of gender, race and ethnicity, and cultural and language needs. Such plans, programs, and services shall be developed in cooperation with other agencies and departments of the state, local governments, community organizations and entities, or other organizations and individuals. The office shall prepare and submit a written report to the governor, the speaker of the assembly, and temporary president of the senate that sets forth the progress of the office in the development of such plans, programs, and services by December first, two thousand nineteen, and biennially thereafter. In addition to delineating the progress the office has made, such report shall also include information on specific suicide prevention services and program initiatives developed and implemented to address the needs of high risk minority groups or special populations, including but not limited to latina and latino adolescents, black youth, individuals residing in rural communities, veterans, members of the lesbian, gay, bisexual and transgender community, and any other group deemed high risk or underserved by the office.

§ 2. This act shall take effect April 1, 2021.

PART TT

Section 1. Section 2807-m of the public health law is amended by adding a new subdivision 7 to read as follows:

7. Notwithstanding any inconsistent provisions of section one hundred twelve or one hundred sixty-three of the state finance law or any other law to the contrary, for the period beginning on April first, two thousand twenty-one and annually thereafter an amount of one million one hundred thousand dollars shall be set aside and reserved by the commissioner from the regional pools established under subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of expanding community-based training of medical students. In addition, for the period beginning on April first, two thousand twenty-one and annually thereafter, an amount of one million one hundred thousand dollars shall be set

aside and reserved by the commissioner from the regional pools established under subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of post-secondary training of health care professionals who will achieve specific program outcomes within the New York state area health education center program. The New York state area health education center program shall report to the commissioner on an annual basis regarding the use of funds for each purpose in any form and manner as specified by the commissioner.

§ 2. This act shall take effect April 1, 2021.

PART UU

Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 1 of part Y of chapter 57 of the laws of 2019, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and ending March 31, [~~2020~~] 2021, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement, provided that the commissioners of the office for people with developmental disabilities, the office of mental health, and the office of [~~alcoholism and substance abuse services~~] addiction services and supports shall not include a COLA beginning April 1, 2017 and ending March 31, 2021.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [~~2020~~] 2021 and [~~ending March 31, 2023~~] every year thereafter, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

§ 2. Section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, is amended by adding a new subdivision 3-g to read as follows:

3-g. Notwithstanding any other provision of law to the contrary, and subject to available appropriations therefore, for all eligible programs as determined pursuant to subdivision four of this section, the commissioners shall provide funding to support a one percent (1.0%) cost of living adjustment, as determined pursuant to subdivision three-c of this section, beginning April 1, 2021. Such cost of living adjustment shall continue to be provided every year thereafter in an amount determined pursuant to subdivision three-c of this section.

§ 3. Section 4 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 1 of part I of chapter 60 of the laws of 2014, is amended to read as follows:

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2006; provided section one of this act shall expire and be deemed repealed April 1, [~~2019~~] 2024; provided, further, that sections two and three of this act shall expire and be deemed repealed December 31, 2009.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs made by sections one and two of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART VV

Section 1. The public health law is amended by adding a new section 2807-o to read as follows:

§ 2807-o. Early intervention services pool. 1. Definitions. The following words or phrases as used in this section shall have the following meanings:

(a) "Early intervention services" shall mean services delivered to an eligible child, pursuant to an individualized family service plan under the early intervention program.

(b) "Early intervention program" shall mean the early intervention program for toddlers with disabilities and their families as created by title two-A of article twenty-five of this chapter.

(c) "Municipality" shall mean any county outside of the city of New York or the city of New York.

2. Payments for early intervention services. (a) The commissioner shall, from funds allocated for such purpose under paragraph (g) of subdivision six of section twenty-eight hundred seven-s of this article, make payments to municipalities and the state for the delivery of early intervention services.

(b) Payments under this subdivision shall be made to municipalities and the state by the commissioner. Each municipality and the state of New York shall receive a share of such payments equal to its proportionate share of the total approved statewide dollars not reimbursable by the medical assistance program paid to providers of early intervention services by the state and municipalities on account of early intervention services in the last complete state fiscal year for which such data is available.

§ 2. Subdivision 6 of section 2807-s of the public health law is amended by adding two new paragraphs (g) and (h) 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.

(h) The amount specified in paragraph (g) of this subdivision shall be allocated under section twenty-eight hundred seven-o of this article among the municipalities 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.

§ 3. Subdivision 7 of section 2807-s of the public health law is amended by adding a new paragraph (d) to read as follows:

(d) funds shall be added to the funds collected by the commissioner for distribution in accordance with section twenty-eight hundred seven-o of this article, in the following amount: forty million dollars for the period beginning April first, two thousand twenty-two, and continuing each state fiscal year thereafter.

§ 4. Subdivision 1 of section 2557 of the public health law, as amended by section 4 of part C of chapter 1 of the laws of 2002, is amended to read as follows:

1. The approved costs for an eligible child who receives an evaluation and early intervention services pursuant to this title shall be a charge upon the municipality wherein the eligible child resides or, where the services are covered by the medical assistance program, upon the social services district of fiscal responsibility with respect to those eligible children who are also eligible for medical assistance. All approved costs shall be paid in the first instance and at least quarterly by the appropriate governing body or officer of the municipality upon vouchers presented and audited in the same manner as the case of other claims against the municipality. Notwithstanding the insurance law or regulations thereunder relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made pursuant to this title. Notwithstanding the insurance law or any other law or agreement to the contrary, benefits under this title shall be considered secondary to [~~any plan of insurance or state government benefit~~] the medical assistance program under which an eligible child may have coverage. [~~Nothing in this section shall increase or enhance coverages provided for within an insurance contract subject to the provisions of this title.~~]

§ 5. Subdivision 2 of section 2557 of the public health law, as amended by section 9-a of part A of chapter 56 of the laws of 2012, is amended to read as follows:

2. The department shall reimburse the approved costs paid by a municipality for the purposes of this title, other than those reimbursable by the medical assistance program [~~or by third party payors~~], in an amount of fifty percent of the amount expended in accordance with the rules and regulations of the commissioner; provided, however, that in the discretion of the department and with the approval of the director of the division of the budget, the department may reimburse municipalities in an amount greater than fifty percent of the amount expended. Such state reimbursement to the municipality shall not be paid prior to April first of the year in which the approved costs are paid by the municipality, provided, however that, subject to the approval of the director of the budget, the department may pay such state aid reimbursement to the municipality prior to such date.

§ 6. The section heading of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, is amended to read as follows:

[~~Third party insurance and medical~~] Medical assistance program payments.

§ 7. Subdivision 3 of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, paragraphs (a), (c) and (d) as amended by section 11 of part A of chapter 56 of the laws of 2012 and paragraph (b) as further amended by section 104 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

3. (a) [~~Providers of evaluations and early intervention services, hereinafter collectively referred to in this subdivision as "provider" or "providers", shall in the first instance and where applicable, seek payment from all third party payors including governmental agencies prior to claiming payment from a given municipality for evaluations conducted under the program and for services rendered to eligible children, provided that, the obligation to seek payment shall not apply to a payment from a third party payor who is not prohibited from applying~~

~~such payment, and will apply such payment, to an annual or lifetime limit specified in the insured's policy.~~

~~(i) Parents shall provide the municipality and service coordinator information on any insurance policy, plan or contract under which an eligible child has coverage.~~

~~(ii)~~] Parents shall provide the municipality and the service coordinator with a written referral from a primary care provider as documentation, for eligible children, of the medical necessity of early intervention services.

[~~(iii) providers~~] (b) Providers shall utilize the department's fiscal agent and data system for claiming payment for evaluations and services rendered under the early intervention program.

[~~(b) The commissioner, in consultation with the director of budget and the superintendent of financial services, shall promulgate regulations providing public reimbursement for deductibles and copayments which are imposed under an insurance policy or health benefit plan to the extent that such deductibles and copayments are applicable to early intervention services.~~

~~(c) Payments made for early intervention services under an insurance policy or health benefit plan, including payments made by the medical assistance program or other governmental third party payor, which are provided as part of an IFSP pursuant to section twenty-five hundred forty-five of this title shall not be applied by the insurer or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan, pursuant to section eleven of the chapter of the laws of nineteen hundred ninety-two which added this title.~~

~~(d)~~] (c) A municipality, or its designee, and a provider shall be subrogated, to the extent of the expenditures by such municipality or for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from [~~third party reimbursement~~] the medical assistance program. The provider shall submit notice to the insurer or plan administrator of his or her exercise of such right of subrogation upon the provider's assignment as the early intervention service provider for the child. The right of subrogation does not attach to benefits paid or provided [~~under any health insurance policy or health benefits plan~~] prior to receipt of written notice of the exercise of subrogation rights [~~by the insurer or plan administrator providing such benefits~~]. Notwithstanding any inconsistent provision of this title, except as provided for herein, no third party payor other than the medical assistance program shall be required to reimburse for early intervention services provided under this title.

§ 8. Subdivision 3 of section 2543 of the public health law is REPEALED.

§ 9. Section 3235-a of the insurance law is REPEALED.

§ 10. Subparagraph (F) of paragraph 25 of subsection (i) of section 3216 of the insurance law is REPEALED.

§ 11. Subparagraph (F) of paragraph 17 of subsection (1) of section 3221 of the insurance law is REPEALED.

§ 12. Paragraph 6 of subsection (ee) of section 4303 of the insurance law is REPEALED.

§ 13. This act shall take effect January 1, 2022; provided, however, that the amendments to section 2807-s of the public health law made by sections two and three of this act shall not affect the expiration of such section and shall be deemed to expire therewith. 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 by the commissioner of health, on or before such effective date.

PART WW

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

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

§ 2. This act shall take effect immediately.

PART XX

Section 1. Subparagraph (iv) of paragraph (a) of subdivision 2 of section 4900 of the public health law, as added by section 42 of subpart A of part BB of chapter 57 of the laws of 2019, is amended and a new subparagraph (v) is added to read as follows:

(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; [~~and~~] 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

§ 2. Paragraph (b) of subdivision 2 of section 4900 of the public health law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

(b) for purposes of title two of this article:

(i) a physician who:

(A) possesses a current and valid non-restricted license to practice medicine;

(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 appeal;

(C) has been practicing in such area of specialty for a period of at least five years; and

(D) is knowledgeable about the health care service or treatment under appeal; 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;

(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 appeal;

(C) has been practicing in such area of specialty for a period of at least five years;

(D) is knowledgeable about the health care service or treatment under appeal; and

(E) 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) 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.

§ 3. Subdivision 2-a of section 4900 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

2-a. "Clinical standards" means those guidelines and standards set forth in the utilization review plan by the utilization review agent whose adverse determination is under appeal or, in the case of medically fragile children, those guidelines and standards as required by section forty-nine hundred three-a of this article.

§ 4. Paragraph (c) of subdivision 10 of section 4900 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(c) a description of practice guidelines and standards used by a utilization review agent in carrying out a determination of medical necessity, which in the case of medically fragile children shall incorporate the standards required by section forty-nine hundred three-a of this article;

§ 5. Section 4900 of the public health law is amended by adding a new subdivision 11 to read as follows:

11. "Medically fragile child" means 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 (a) is technologically dependent for life or health sustaining functions, (b) requires a complex medication regimen or medical interventions to maintain or to improve their health status, or (c) 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. Chronic debilitating conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. The term "medically fragile child" shall also include severe conditions, including but not limited to traumatic brain injury, which typically require care in a specialty care center for medically fragile children, even though the child does not have a chronic debilitating condition or also meet one of the three conditions of this subdivision. In order to facilitate the prompt and convenient identification of particular patient care situations meeting the definitions of this subdivision, the commissioner may issue written guidance listing (by diagnosis codes, utilization thresholds, or other available coding or commonly used medical classifications) the types of patient care needs which are deemed to meet this definition. Notwithstanding the definitions set forth in this subdivision, any patient which has received prior approval from a utilization review agent for admission to a specialty care facility for medically fragile children shall be considered a medically fragile child at least until discharge from that facility occurs.

§ 6. The public health law is amended by adding a new section 4903-a to read as follows:

§ 4903-a. Utilization review determinations for medically fragile children. 1. Notwithstanding any inconsistent provision of the utilization review agent's clinical standards, the utilization review agent shall administer and apply the clinical standards (and make determinations of medical necessity) regarding medically fragile children in accordance with the requirements of this section. If the utilization review agent is a separate entity from the health maintenance organiza-

tion certified under article forty-four of this chapter, the health maintenance organization shall make contractual or other arrangements in order to facilitate the utilization review agent's compliance with this section.

2. In the case of a medically fragile child, the term "medically necessary" shall mean health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability. When applied to the circumstances of any particular medically fragile child, the term "medically necessary" shall include (a) the care or services that are essential to prevent, diagnose, prevent the worsening of, alleviate or ameliorate the effects of an illness, injury, disability, disorder or condition, (b) the care or services that are essential to the overall physical, cognitive and mental growth and developmental needs of the child, and (c) the care or services that will assist the child to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the child and those functional capacities that are appropriate for individuals of the same age as the child. The utilization review agent shall base its determination on medical and other relevant information provided by the child's primary care provider, other health care providers, school, local social services, and/or local public health officials that have evaluated the child, and the utilization review agent will ensure the care and services are provided in sufficient amount, duration and scope to reasonably be expected to produce the intended results and to have the expected benefits that outweigh the potential harmful effects.

3. Utilization review agents shall undertake the following with respect to medically fragile children:

(a) Consider as medically necessary all covered services that assist medically fragile children in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. Health maintenance organizations must continue to cover services until that child achieves age-appropriate functional capacity. A managed care provider, authorized by section three hundred sixty-four-j of the social services law, shall also be required to make payment for covered services required to comply with federal Early Periodic Screening, Diagnosis, and Treatment ("EPSDT") standards, as specified by the commissioner of health.

(b) Shall not base determinations solely upon review standards applicable to (or designed for) adults to medically fragile children. Adult standards include, but are not limited to, Medicare rehabilitation standards and the "Medicare 3 hour rule." Determinations have to take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.

(c) Accommodate unusual stabilization and prolonged discharge plans for medically fragile children, as appropriate. Issues utilization review agents must consider when developing and approving discharge plans include, but are not limited to: sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults; necessary training of parents or other adults to care for medically fragile children at home; unusual discharge delays encountered if parents or other responsible adults decline or are slow to assume full responsibility for caring for medically fragile children; the need to await an appropriate home or

home-like environment rather than discharge to a housing shelter or other inappropriate setting for medically fragile children, the need to await construction adaptations to the home (such as the installation of generators or other equipment); and lack of available suitable specialized care (such as unavailability of pediatric nursing home beds, pediatric ventilator units, pediatric private duty nursing in the home, or specialized pediatric home care services). Utilization review agents must develop a person centered discharge plan for the child taking the above situations into consideration.

(d) It is the utilization review agent's network management responsibility to identify an available provider of needed covered services, as determined through a person centered care plan, to effect safe discharge from a hospital or other facility; payments shall not be denied to a discharging hospital or other facility due to lack of an available post-discharge provider as long as they have worked with the utilization review agent to identify an appropriate provider. Utilization review agents are required to approve the use of out-of-network providers if the health maintenance organization does not have a participating provider to address the needs of the child.

(e) This section does not limit any other rights the medically fragile child may have, including the right to appeal the denial of out of network coverage at in-network cost sharing levels where an appropriate in-network provider is not available pursuant to subdivision one-b of section forty-nine hundred four of this title.

(f) Utilization review agents must ensure that medically fragile children receive services from appropriate providers that have the expertise to effectively treat the child and must contract with providers with demonstrated expertise in caring for the medically fragile children. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the utilization review agent for out-of-network providers when participating providers cannot meet the child's needs. The utilization review agent must authorize services as fast as the enrollee's condition requires and in accordance with established timeframes in the contracts or policy forms.

4. A health maintenance organization shall have a procedure by which an enrollee who is a medically fragile child who requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center for medically fragile children. If the health maintenance organization, or the primary care provider or the specialist treating the patient, in consultation with a medical director of the utilization review agent, determines that the enrollee's care would most appropriately be provided by such a specialty care center, the organization shall refer the enrollee to such center. In no event shall a health maintenance organization be required to permit an enrollee to elect to have a non-participating specialty care center, unless the organization does not have an appropriate specialty care center to treat the enrollee's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the health maintenance organization, in consultation with the primary care provider, if any, or a specialist treating the patient, and the enrollee or the enrollee's designee. If an organization refers an enrollee to a specialty care center that does not participate in the organization's network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services

received within the network. For purposes of this section, a specialty care center for medically fragile children shall mean a children's hospital as defined pursuant to subparagraph (iv) of paragraph (e-2) of subdivision four of section twenty-eight hundred seven-c of this chapter, a residential health care facility affiliated with such a children's hospital, any residential health care facility with a specialty pediatric bed average daily census during two thousand seventeen of fifty or more patients, or a facility which satisfies such other criteria as the commissioner may designate.

5. When rendering or arranging for care or payment, both the provider and the health maintenance organization shall inquire of, and shall consider the desires of the family of a medically fragile child including, but not limited to, the availability and capacity of the family, the need for the family to simultaneously care for the family's other children, and the need for parents to continue employment.

6. The health maintenance organization must pay at least eighty-five percent (unless a different percentage or method has been mutually agreed to) of the facility's negotiated acute care rate for all days of inpatient hospital care at a specialty care center for medically fragile children when the health maintenance organization and the specialty care facility mutually agree the patient is ready for discharge from the specialty care center to the patient's home but requires specialized home services that are not available or in place, or the patient is awaiting discharge to a residential health care facility when no residential health care facility bed is available given the specialized needs of the medically fragile child. The health maintenance organization must pay at least the facility's Medicaid skilled nursing facility rate, unless a different rate has been mutually negotiated, for all days of residential health care facility care at a specialty care center for medically fragile children when the health maintenance organization and the specialty care facility mutually agree the patient is ready for discharge from the specialty care center to the patient's home but requires specialized home services that are not available or in place. Such requirements shall apply until the health plan can identify and secure admission to an alternate provider rendering the necessary level of services. The specialty care center must cooperate with the health maintenance organization's placement efforts.

7. In the event a health maintenance organization enters into a participation agreement with a specialty care center for medically fragile children in this state, the requirements of this section shall apply to such participation agreement and to all claims submitted to, or payments made by, any other health maintenance organizations, insurers or payors making payment to the specialty care center pursuant to the provisions of that participation agreement.

8. (a) The commissioner shall designate a single set of clinical standards applicable to all utilization review agents regarding pediatric extended acute care stays (defined for the purposes of this section as discharge from one acute care hospital followed by immediate admission to a second acute care hospital; not including transfers of case payment cases as defined in section twenty-eight hundred seven-c of this chapter). The standards shall be adapted from national long term acute care hospital standards for adults and shall be approved by the commissioner, after consultation with one or more specialty care centers for medically fragile children. The standards shall include, but not be limited to, specifications of the level of care supports in the patient's home, at a skilled nursing facility or other setting, that must be in place in

order to safely and adequately care for a medically fragile child before medically complex acute care can be deemed no longer medically necessary. The standards designated by the commissioner shall pre-empt the clinical standards, if any, for pediatric extended acute care set forth in the utilization review plan by the utilization review agent.

(b) The commissioner shall designate a single set of supplemental clinical standards (in addition to the clinical standards selected by the utilization review agent) applicable to all utilization review agents regarding acute and sub-acute inpatient rehabilitation for medically fragile children. The supplemental standards shall specify the level of care supports in the patient's home, at a skilled nursing facility or other setting, that must be in place in order to safely and adequately care for a medically fragile child before acute or sub-acute inpatient rehabilitation can be deemed no longer medically necessary. The supplemental standards designated by the commissioner shall pre-empt the clinical standards, if any, regarding readiness for discharge of medically fragile children from acute or sub-acute inpatient rehabilitation, as set forth in the utilization review plan by the utilization review agent.

9. In all instances the utilization review agent shall defer to the recommendations of the referring physician to refer a medically fragile child for care at a particular specialty provider of care to medically fragile children, or the recommended treatment plan by the treating physician at a specialty care center for medically fragile children, except where the utilization review agent has determined, by clear and convincing evidence, that: (a) the recommended provider or proposed treatment plan is not in the best interest of the medically fragile child, or (b) an alternative provider offering substantially the same level of care in accordance with substantially the same treatment plan is available from a lower cost provider.

§ 7. Subparagraph (D) of paragraph 1 of subsection (b) of section 4900 of the insurance law, as added by section 36 of subpart A of part BB of chapter 57 of the laws of 2019, is amended and a new subparagraph (E) is added to read as follows:

(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; [~~and~~] 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

§ 8. Paragraph 2 of subsection (b) of section 4900 of the insurance law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

(2) for purposes of title two of this article:

(A) a physician who:

(i) possesses a current and valid non-restricted license to practice medicine;

(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 appeal;

(iii) has been practicing in such area of specialty for a period of at least five years; and

(iv) is knowledgeable about the health care service or treatment under appeal; 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;

(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 appeal;

(iii) has been practicing in such area of specialty for a period of at least five years;

(iv) is knowledgeable about the health care service or treatment under appeal; and

(v) 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) 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.

§ 9. Subsection (b-1) of section 4900 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(b-1) "Clinical standards" means those guidelines and standards set forth in the utilization review plan by the utilization review agent whose adverse determination is under appeal **or, in the case of medically fragile children those guidelines and standards as required by section forty-nine hundred three-a of this article**.

§ 10. Subsection (j) of section 4900 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(j) "Utilization review plan" means: (1) a description of the process for developing the written clinical review criteria; (2) a description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to, a set of specific written clinical review criteria; (3) a description of practice guidelines and standards used by a utilization review agent in carrying out a determination of medical necessity**, which, in the case of medically fragile children, shall incorporate the standards required by**

section forty-nine hundred three-a of this article; (4) the procedures for scheduled review and evaluation of the written clinical review criteria; and (5) a description of the qualifications and experience of the health care professionals who developed the criteria, who are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of utilization review.

§ 11. Section 4900 of the insurance law is amended by adding a new subsection (k) to read as follows:

(k) "Medically fragile child" means 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: (1) is technologically dependent for life or health sustaining functions; (2) requires a complex medication regimen or medical interventions to maintain or to improve their health status; or (3) 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. Chronic debilitating conditions include, but are not limited to, bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, microcephaly, pulmonary hypertension, and muscular dystrophy. The term "medically fragile child" shall also include severe conditions, including but not limited to traumatic brain injury, which typically require care in a specialty care center for medically fragile children, even though the child does not have a chronic debilitating condition or also meet one of the three conditions of this subsection. In order to facilitate the prompt and convenient identification of particular patient care situations meeting the definitions of this subsection, the superintendent, after consulting with the commissioner of health, may issue written guidance listing (by diagnosis codes, utilization thresholds, or other available coding or commonly used medical classifications) the types of patient care needs which are deemed to meet this definition. Notwithstanding the definitions set forth in this subsection, any patient which has received prior approval from a utilization review agent for admission to a specialty care facility for medically fragile children shall be considered a medically fragile child at least until discharge from that facility occurs.

§ 12. The insurance law is amended by adding a new section 4903-a to read as follows:

§ 4903-a. Utilization review determinations for medically fragile children. (a) Notwithstanding any inconsistent provision of the utilization review agent's clinical standards, the utilization review agent shall administer and apply the clinical standards (and make determinations of medical necessity) regarding medically fragile children in accordance with the requirements of this section. If the utilization review agent is a separate entity from the health care plan, the health care plan shall make contractual or other arrangements in order to facilitate the utilization review agent's compliance with this section.

(b) In the case of a medically fragile child, the term "medically necessary" shall mean health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability. When applied to the circumstances of any particular medically fragile child, the term "medically necessary" shall include: (1) the care or services that are essential to prevent, diagnose, prevent the worsening of, alleviate or

ameliorate the effects of an illness, injury, disability, disorder or condition; (2) the care or services that are essential to the overall physical, cognitive and mental growth and developmental needs of the child; and (3) the care or services that will assist the child to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the child and those functional capacities that are appropriate for individuals of the same age as the child. The utilization review agent shall base its determination on medical and other relevant information provided by the child's primary care provider, other health care providers, school, local social services, and/or local public health officials that have evaluated the child, and the utilization review agent will ensure the care and services are provided in sufficient amount, duration and scope to reasonably be expected to produce the intended results and to have the expected benefits that outweigh the potential harmful effects.

(c) Utilization review agents shall undertake the following with respect to medically fragile children:

(1) Consider as medically necessary all covered services that assist medically fragile children in reaching their maximum functional capacity, taking into account the appropriate functional capacities of children of the same age. Utilization review agents must continue to cover services until that child achieves age-appropriate functional capacity.

(2) Shall not base determinations solely upon review standards applicable to (or designed for) adults to medically fragile children. Adult standards include, but are not limited to, Medicare rehabilitation standards and the "Medicare 3 hour rule." Determinations have to take into consideration the specific needs of the child and the circumstances pertaining to their growth and development.

(3) Accommodate unusual stabilization and prolonged discharge plans for medically fragile children, as appropriate. Issues utilization review agents must consider when developing and approving discharge plans include, but are not limited to: sudden reversals of condition or progress, which may make discharge decisions uncertain or more prolonged than for other children or adults; necessary training of parents or other adults to care for medically fragile children at home; unusual discharge delays encountered if parents or other responsible adults decline or are slow to assume full responsibility for caring for medically fragile children; the need to await an appropriate home or home-like environment rather than discharge to a housing shelter or other inappropriate setting for medically fragile children, the need to await construction adaptations to the home (such as the installation of generators or other equipment); and lack of available suitable specialized care (such as unavailability of pediatric nursing home beds, pediatric ventilator units, pediatric private duty nursing in the home, or specialized pediatric home care services). Utilization review agents must develop a person centered discharge plan for the child taking the above situations into consideration.

(4) It is the utilization review agents network management responsibility to identify an available provider of needed covered services, as determined through a person centered care plan, to effect safe discharge from a hospital or other facility; payments shall not be denied to a discharging hospital or other facility due to lack of an available post-discharge provider as long as they have worked with the utilization review agent to identify an appropriate provider. Utilization review agents are required to approve the use of out-of-network providers if

they do not have a participating provider to address the needs of the child.

(5) This section does not limit any other rights a medically fragile child may have, including the right to appeal the denial of out of network coverage at in-network cost sharing levels where an appropriate in-network provider is not available pursuant to subsection a-two of section four thousand nine hundred four of this title.

(6) Utilization review agents must ensure that medically fragile children receive services from appropriate providers that have the expertise to effectively treat the child and must contract with providers with demonstrated expertise in caring for the medically fragile children. Network providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the utilization review agent for out-of-network providers when participating providers cannot meet the child's needs. The utilization review agent must authorize services as fast as the insured's condition requires and in accordance with established timeframes in the contracts or policy forms.

(d) A utilization review agent shall have a procedure by which an insured who is a medically fragile child who requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center for medically fragile children. If the utilization review agent, or the primary care provider or the specialist treating the patient, in consultation with a medical director of the utilization review agent, determines that the insured's care would most appropriately be provided by such a specialty care center, the utilization review agent shall refer the insured to such center. In no event shall a utilization review agent be required to permit an insured to elect to have a non-participating specialty care center, unless the health care plan does not have an appropriate specialty care center to treat the insured's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the utilization review agent, in consultation with the primary care provider, if any, or a specialist treating the patient, and the insured or the insured's designee. If a utilization review agent refers an insured to a specialty care center that does not participate in the health care plan's network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the insured beyond what the insured would otherwise pay for services received within the network. For purposes of this section, a specialty care center for medically fragile children shall mean a children's hospital as defined pursuant to subparagraph (iv) of paragraph (e-2) of subdivision four of section two thousand eight hundred seven-c of the public health law, a residential health care facility affiliated with such a children's hospital, any residential health care facility with a specialty pediatric bed average daily census during two thousand seventeen of fifty or more patients, or a facility which satisfies such other criteria as the commissioner of health may designate.

(e) When rendering or arranging for care or payment, both the provider and the health care plan shall inquire of, and shall consider the desires of, the family of a medically fragile child including, but not limited to, the availability and capacity of the family, the need for the family to simultaneously care for the family's other children, and the need for parents to continue employment.

(f) The health care plan must pay at least eighty-five percent (unless a different percentage or method has been mutually agreed to) of the

facility's negotiated acute care rate for all days of inpatient hospital care at a specialty care center for medically fragile children when the insurer and the specialty care facility mutually agree the patient is ready for discharge from the specialty care center to the patient's home but requires specialized home services that are not available or in place, or the patient is awaiting discharge to a residential health care facility when no residential health care facility bed is available given the specialized needs of the medically fragile child. The health care plan must pay at least the facility's skilled nursing Medicaid facility rate, unless a different rate has been mutually negotiated, for all days of residential health care facility care at a specialty care center for medically fragile children when the insurer and the specialty care facility mutually agree the patient is ready for discharge from the specialty care center to the patient's home but requires specialized home services that are not available or in place. Such requirements shall apply until the health care plan can identify and secure admission to an alternate provider rendering the necessary level of services. The specialty care center must cooperate with the health care plan's placement efforts.

(g) In the event a health care plan enters into a participation agreement with a specialty care center for medically fragile children in this state, the requirements of this section shall apply to that participation agreement and to all claims submitted to, or payments made by, any other insurers, health maintenance organizations or payors making payment to the specialty care center pursuant to the provisions of that participation agreement.

(h) (1) The superintendent, after consulting with the commissioner of health, shall designate a single set of clinical standards applicable to all utilization review agents regarding pediatric extended acute care stays (defined for the purposes of this section as discharge from one acute care hospital followed by immediate admission to a second acute care hospital; not including transfers of case payment cases as defined in section two thousand eight hundred seven-c of the public health law). The standards shall be adapted from national long term acute care hospital standards for adults and shall be approved by the superintendent, after consultation with one or more specialty care centers for medically fragile children. The standards shall include, but not be limited to, specifications of the level of care supports in the patient's home, at a skilled nursing facility or other setting, that must be in place in order to safely and adequately care for a medically fragile child before medically complex acute care can be deemed no longer medically necessary. The standards designated by the commissioner shall pre-empt the clinical standards, if any, for pediatric extended acute care set forth in the utilization review plan by the utilization review agent.

(2) The superintendent, after consulting with the commissioner of health, shall designate a single set of supplemental clinical standards (in addition to the clinical standards selected by the utilization review agent) applicable to all utilization review agents regarding acute and sub-acute inpatient rehabilitation for medically fragile children. The standards shall specify the level of care supports in the patient's home, at a skilled nursing facility or other setting, that must be in place in order to safely and adequately care for a medically fragile child before acute or sub-acute inpatient rehabilitation can be deemed no longer medically necessary. The supplemental standards designated by the superintendent shall pre-empt the clinical standards, if any, regarding readiness for discharge of medically fragile children

from acute or sub-acute inpatient rehabilitation, as set forth in the utilization review plan by the utilization review agent.

(i) In all instances the utilization review agent shall defer to the recommendations of the referring physician to refer a medically fragile child for care at a particular specialty provider of care to medically fragile children, or the recommended treatment plan by the treating physician at a specialty care center for medically fragile children, except where the utilization review agent has determined, by clear and convincing evidence, that: (1) the recommended provider or proposed treatment plan is not in the best interest of the medically fragile child; or (2) an alternative provider offering substantially the same level of care in accordance with substantially the same treatment plan is available from a lower cost provider.

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

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

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