STATE OF NEW YORK

S. 8307--C A. 8807--C

SENATE - ASSEMBLY

January 17, 2024

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

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

AN ACT to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to known and projected department of health state fund medicaid expenditures (Part A); to amend the public health law, in relation to extending certain provisions related to the issuance of accountable care organization certifications and state oversight of antitrust provisions; to amend part D of chapter 56 of the laws of 2013 amending the social services law relating to eligibility conditions, chapter 649 of the laws of 1996 amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, part V of chapter 57 of the laws of 2022 amending the public health law and the insurance law relating to reimbursement for commercial and Medicaid services provided via telehealth, chapter 659 of the laws of 1997 amending the public health law and other laws relating to creation of continuing care retirement communities, part NN of chapter 57 of the laws of 2018 amending the public health law and the state finance law relating to enacting the opioid stewardship act, part II of chapter 54 of the laws of 2016 amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements

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

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for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, part B of chapter 57 of the laws of 2015 amending the social services law and other laws relating to energy audits and/or disaster preparedness reviews of residential healthcare facilities by the commissioner, part H of chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, part Q of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the closure or transfer of a state-operated individualized residential alternative, and chapter 769 of the laws of 2023, amending the public health law relating to the adult cystic fibrosis assistance program, in relation to the effectiveness thereof; and to amend chapter 670 of the laws of 2021, requiring the office for people with developmental disabilities to establish the care demonstration program, in relation to the establishment of a care demonstration program and the effectiveness thereof (Part B); to amend the education law, in relation to removing the exemption for school psychologists to render early intervention services; and to amend chapter 217 of the laws of 2015, amending the education law relating to certified school psychologists and special education services and programs for preschool children with handicapping conditions, in relation to the effectiveness thereof (Part C); to amend the public health law, in relation to reducing the hospital capital rate add-on; to amend part ZZ of chapter 56 of the laws of 2020 amending the tax law and the social services law relating to certain Medicaid management, in relation to the effectiveness thereof; to amend part E of chapter 57 of the laws of 2015, amending the public health law relating to the payment of certain funds for uncompensated care, in relation to certain payments being made as outpatient upper payment limit payments for outpatient hospital services during certain state fiscal years and calendar years; to amend part B of chapter 57 of the laws of 2015, amending the social services law relating to supplemental rebates, in relation to authorizing the department of health to increase operating cost component of rates of payment for general hospital outpatient services and authorizing the department of health to pay a public hospital adjustment to public general hospitals during certain state fiscal years and calendar years; to amend the public health law, in relation to authorizing the commissioner to make additional inpatient hospital payments during certain state fiscal years and calendar years; and to amend part B of chapter 58 of the laws of 2010, amending the social services law and the public health law relating to prescription drug coverage for needy persons and health care initiatives pools, in relation to authorizing the department of health to make Medicaid payment increases for county operated free-standing clinics during certain state fiscal years and calendar years (Part D); to amend the public health law, in relation to freezing the operating component of the rates for skilled nursing facilities, reducing the capital component of the rates for skilled nursing facilities by an additional ten percent, and eligibility for admission to the New York state veterans' home (Part E); to amend the social services law, in relation to the special needs assisted living residence voucher program (Part F); intentionally omitted (Part G); to amend part I of chapter 57 of the laws of 2022, providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to eliminating the one percent rate increase to managed care organizations (Part H); to amend the social services law, in relation to copayments for drugs; to amend the

public health law, in relation to the preferred drug program; to amend the public health law, in relation to the Medicaid drug cap and pharmacy cost reporting; and to amend the social services law, in relation to coverage for drugs authorized by accelerated approval (Part I); to amend the social services law, in relation to renaming the basic health program to the essential plan; to amend part H of chapter 57 of the laws of 2021, amending the social services law relating to eliminating consumer-paid premium payments in the basic health program, in relation to the effectiveness thereof; to amend part BBB of chapter 56 of the laws of 2022, amending the public health law and other laws relating to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent, in relation to extending certain provisions related to providing long-term services and supports under the essential plan; and to amend the public health law, in relation to adding references to the 1332 state innovation waiver, providing a new subsidy to assist low-income New Yorkers with the payment of premiums, cost-sharing or both through the marketplace, and adding the 1332 state innovation program to the functions of the marketplace (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 insurance coverage paid for by funds from the hospital excess liability pool and extending the effectiveness of certain provisions thereof; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017 amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part K); intentionally omitted (Part L); to amend the social services law and the public health law, in relation to authorizing continuous coverage in Medicaid and child health plus, for eligible children ages zero to six (Part M); intentionally omitted (Part N); to amend the public health law, in relation to expanding financial assistance; and to amend the general business law, in relation to additional consumer protection for medical debt and restricting the applications for and use of credit cards and medical financial products (Part O); to amend part C of chapter 57 of the laws of 2022 amending the public health law and the education law relating to allowing pharmacists to direct limited service laboratories and order and administer COVID-19 and influenza tests and modernizing nurse practitioners, and chapter 21 of the laws of 2011 amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness thereof (Part P); intentionally omitted (Part Q); intentionally omitted (Part R); to amend the public health law, in relation to establishing the healthcare safety net transformation program (Part S); intentionally omitted (Part T); intentionally omitted (Part U); intentionally omitted (Part V); intentionally omitted (Part W); intentionally omitted (Part X); 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 the effectiveness thereof (Part Y); to amend part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to the effectiveness thereof (Part Z); to amend the insurance law, in relation to setting minimal reimbursement for behavioral health treatment (Part AA); to amend chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, in relation to the effectiveness of certain provisions thereof (Part BB); intentionally omitted (Part CC); 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 DD); intentionally omitted (Part EE); to establish a cost of living adjustment for designated human services programs (Part FF); to amend the social services law, in relation to providing contracting flexibility in relation to 1115 medicaid waivers (Part GG); to amend the social services law, in relation to statewide fiscal intermediaries and a registration process for such intermediaries; to amend the social services law, in relation to the consumer directed personal assistance program; and to repeal certain provisions of the social services law relating thereto (Part HH); to amend the public health law and the state finance law, in relation to establishing a New York managed care organization provider tax (Part II); to amend the social services law, in relation to coverage for services provided by school-based health centers for medical assistance recipients (Part JJ); to amend the public health law, in relation to the creation of a community doula expansion grant program; and to repeal such program upon expiration thereof (Part KK); to amend the public health law, in relation to reimbursement rates for medically fragile children and pediatric diagnostic and treatment centers; and providing for the repeal of such provisions upon the expiration thereof (Part LL); to amend the executive law, in relation to establishing the community advisory board for the modernization and revitalization of SUNY downstate health sciences university (Part MM); and to amend part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to certain Medicaid payments made for hospital services (Part NN)

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 2024-2025 state fiscal year. Each component is wholly contained within a Part identified as Parts A through NN. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that

particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Paragraph (a) of subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 1 of part A of chapter 57 of the laws of 2023, is amended to read as follows:

(a) For state fiscal years 2011-12 through [2024-25] 2025-26, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a quarterly basis, as reflected in quarterly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART B

Section 1. Subdivision p of section 76 of part D of chapter 56 of the laws of 2013 amending the social services law relating to eligibility conditions, as amended by section 2 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

p. the amendments to subparagraph 7 of paragraph (b) of subdivision 1 of section 366 of the social services law made by section one of this act shall expire and be deemed repealed October 1, [2024] 2029.

§ 2. Section 10 of chapter 649 of the laws of 1996 amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, as amended by section 21 of part E of chapter 57 of the laws of 2019, is amended to read as follows:

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided, however, that sections one, two and three of this act shall expire and be deemed repealed [on] March 31, [2025] 2030 provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000.

§ 3. Subdivision 3 of section 2999-p of the public health law, as amended by section 8 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

3. The commissioner may issue a certificate of authority to an entity that meets conditions for ACO certification as set forth in regulations made by the commissioner pursuant to section twenty-nine hundred ninety-nine-q of this article. The commissioner shall not issue any new

certificate under this article after December thirty-first, two thousand [twenty-four] twenty-eight.

§ 4. Subdivision 1 of section 2999-aa of the public health law, as amended by section 9 of part S of chapter 57 of the laws of 2021, 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-four] twenty-eight.

§ 5. Section 7 of part V of chapter 57 of the laws of 2022 amending the public health law and the insurance law relating to reimbursement for commercial and Medicaid services provided via telehealth, is amended to read as follows:

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, this act shall expire and be deemed repealed on and after April 1, [2024] 2026.

§ 6. Section 97 of chapter 659 of the laws of 1997 amending the public health law and other laws relating to creation of continuing care retirement communities, as amended by section 11 of part Z of chapter 57 of the laws of 2018, is amended to read as follows:

§ 97. This act shall take effect immediately, provided, however, that the amendments to subdivision 4 of section 854 of the general municipal law made by section seventy of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided further that sections sixty-seven and sixty-eight of this act shall apply to taxable years beginning on or after January 1, 1998 and provided further that sections eighty-one through eighty-seven of this act shall expire and be deemed repealed on December 31, [2024] 2029 and provided further, however, that the amendments to section ninety of this act shall take effect January 1, 1998 and shall apply to all policies, contracts, certificates, riders or other evidences of coverage of long term care insurance issued, renewed, altered or modified pursuant to section 3229 of the insurance law on or after such date.

§ 7. Section 5 of part NN of chapter 57 of the laws of 2018 amending the public health law and the state finance law relating to enacting the

opioid stewardship act, as amended by section 5 of part XX of chapter 59 of the laws of 2019, is amended to read as follows:

§ 5. This act shall take effect July 1, 2018 and shall expire and be deemed to be repealed on June 30, [2024] 2029, provided that, effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date, and, provided that this act shall only apply to the sale or distribution of opioids in the state of New York on or before December 31, 2018.

§ 8. Section 2 of part II of chapter 54 of the laws of 2016 amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, as amended by section 6 of part CC of chapter 57 of the laws of 2022, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [2024] 2026.

§ 9. Subdivision 5 of section 60 of part B of chapter 57 of the laws of 2015 amending the social services law and other laws relating to energy audits and/or disaster preparedness reviews of residential healthcare facilities by the commissioner, as amended by chapter 125 of the laws of 2021, is amended to read as follows:

5. section thirty-eight of this act shall expire and be deemed repealed July 1, [2024] 2027;

§ 10. Section 7 of part H of chapter 57 of the laws of 2019, amending the public health law relating to waiver of certain regulations, as amended by section 1 of part GG of chapter 57 of the laws of 2022, is amended to read as follows:

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019, provided, however, that section two of this act shall expire on April 1, [2024] 2026.

§ 11. Section 2 of part Q of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the closure or transfer of a state-operated individualized residential alternative, as amended by chapter 176 of the laws of 2022, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [2024] 2026.

§ 12. Subdivision (a) of section 1 of chapter 670 of the laws of 2021, requiring the office for people with developmental disabilities to establish the care demonstration program, is amended to read as follows:

(a) The commissioner of the office for people with developmental disabilities [shall] may, at their discretion, establish the care demonstration program, to utilize the state workforce to provide community based care to individuals with developmental disabilities.

§ 13. Section 3 of chapter 670 of the laws of 2021, requiring the office for people with developmental disabilities to establish the care demonstration program, is amended to read as follows:

§ 3. This act shall take effect immediately and shall expire and be deemed repealed March 31, [2024] 2026.

§ 14. Section 2 of chapter 769 of the laws of 2023, amending the public health law relating to the adult cystic fibrosis assistance program, as amended by chapter 31 of the laws of 2024, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire March 31, [2024] 2025 when upon such date the provisions of this act shall be deemed repealed.

§ 15. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 31, 2024.

PART C

Section 1. Paragraph d of subdivision 6 of section 4410 of the education law, as amended by chapter 217 of the laws of 2015, is amended to read as follows:

d. Notwithstanding any other provision of law to the contrary, the exemption in subdivision one of section seventy-six hundred five of this chapter shall apply to persons employed on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that such person is employed by and under the dominion and control of a center-based program approved pursuant to subdivision nine of this section as a certified school psychologist to provide activities, services and use of the title psychologist to students enrolled in such approved center-based program; and to certified school psychologists employed on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that the school psychologist is employed by and under the dominion and control of a program that has been approved pursuant to paragraph b of subdivision nine of this section, or subdivision nine-a of this section, to conduct a multi-disciplinary evaluation of a preschool child having or suspected of having a disability where authorized by paragraph a [or b] of subdivision six of section sixty-five hundred three-b of this chapter[; and to certified school psychologists employed on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that such psychologist is employed by and under the dominion and control of an agency approved in accordance with title two-A of article twenty-five of the public health law to deliver early intervention program multidisciplinary evaluations, service coordination services and early intervention program services, where authorized by paragraph a or b of subdivision six of section sixty-five hundred three-b of this chapter, each]\, in the course of their employment. Nothing in this section shall be construed to authorize a certified school psychologist or group of such school psychologists to engage in independent practice or practice outside of an employment relationship.

§ 2. Subdivision 1 of section 7605 of the education law, as amended by chapter 217 of the laws of 2015, is amended to read as follows:

1. The activities, services, and use of the title of psychologist, or any derivation thereof, on the part of a person in the employ of a federal, state, county or municipal agency, or other political subdivision, or a chartered elementary or secondary school or degree-granting educational institution insofar as such activities and services are a part of the duties of [his] such salaried position; or on the part of a person in the employ as a certified school psychologist on a full-time or part-time salary basis, which may include on an hourly, weekly, or monthly basis, or on a fee for evaluation services basis provided that such person employed as a certified school psychologist is employed by and under the dominion and control of a preschool special education program approved pursuant to paragraph b of subdivision nine or subdivi-

sion nine-a of section forty-four hundred ten of this chapter to provide activities, services and to use the title "certified school psychologist", so long as this shall not be construed to permit the use of the title "licensed psychologist", to students enrolled in such approved program or to conduct a multidisciplinary evaluation of a preschool child having or suspected of having a disability[; or on the part of a person in the employ as a certified school psychologist on a full-time or part-time salary basis, which may include on an hourly, weekly or monthly basis, or on a fee for evaluation services basis provided that such person employed as a certified school psychologist is employed by and under the dominion and control of an agency approved in accordance with title two-A of article twenty-five of the public health law to deliver early intervention program multidisciplinary evaluations, service coordination services and early intervention program services], where each such preschool special education program [or early intervention provider] is authorized by paragraph a [or b] of subdivision six of section sixty-five hundred [three] three-b of this title[, each] in the course of their employment. Nothing in this subdivision shall be construed to authorize a certified school psychologist or group of such school psychologists to engage in independent practice or practice outside of an employment relationship.

§ 3. Section 3 of chapter 217 of the laws of 2015, amending the education law relating to certified school psychologists and special education services and programs for preschool children with handicapping conditions, as amended by chapter 339 of the laws of 2022, is amended to read as follows:

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 2014, provided, however that the provisions of this act shall expire and be deemed repealed June 30, [2024] 2026.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that sections one and two of this act shall take effect April 1, 2025; provided further, however, that the amendments to paragraph d of subdivision 6 of section 4410 of the education law made by section one of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith; and provided further, however, that the amendments to subdivision 1 of section 7605 of the education law made by section two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

PART D

Section 1. Paragraph (c) of subdivision 8 of section 2807-c of the public health law, as amended by section 1 of part D of chapter 57 of the laws of 2021, is amended to read as follows:

(c) In order to reconcile capital related inpatient expenses included in rates of payment based on a budget to actual expenses and statistics for the rate period for a general hospital, rates of payment for a general hospital shall be adjusted to reflect the dollar value of the difference between capital related inpatient expenses included in the computation of rates of payment for a prior rate period based on a budget and actual capital related inpatient expenses for such prior rate period, each as determined in accordance with paragraph (a) of this subdivision, adjusted to reflect increases or decreases in volume of service in such prior rate period compared to statistics applied in

determining the capital related inpatient expenses component of rates of payment based on a budget for such prior rate period.

For rates effective April first, two thousand twenty through March thirty-first, two thousand twenty-one, the budgeted capital-related expenses add-on as described in paragraph (a) of this subdivision, based on a budget submitted in accordance to paragraph (a) of this subdivision, shall be reduced by five percent relative to the rate in effect on such date; and the actual capital expenses add-on as described in paragraph (a) of this subdivision, based on actual expenses and statistics through appropriate audit procedures in accordance with paragraph (a) of this subdivision shall be reduced by five percent relative to the rate in effect on such date.

For rates effective [on and after] April first, two thousand twenty-one <u>through September thirtieth, two thousand twenty-four</u>, the budgeted capital-related expenses add-on as described in paragraph (a) of this subdivision, based on a budget submitted in accordance to paragraph (a) of this subdivision, shall be reduced by ten percent relative to the rate in effect on such date; and the actual capital expenses add-on as described in paragraph (a) of this subdivision, based on actual expenses and statistics through appropriate audit procedures in accordance with paragraph (a) of this subdivision shall be reduced by ten percent relative to the rate in effect on such date.

<u>For rates effective on and after October first, two thousand twenty-four, the budgeted capital-related expenses add-on as described in paragraph (a) of this subdivision, based on a budget submitted in accordance with paragraph (a) of this subdivision, shall be reduced by twenty percent relative to the rate in effect on such date; and the actual capital expenses add-on as described in paragraph (a) of this subdivision shall be reduced by twenty percent relative to the rate in effect on such date.</u>

For any rate year, all reconciliation add-on amounts calculated [on and after] <u>for the period of</u> April first, two thousand twenty <u>through September thirtieth, two thousand twenty-four</u> shall be reduced by ten percent, and all reconciliation recoupment amounts calculated [on or after] <u>for the period of</u> April first, two thousand twenty <u>through September thirtieth, two thousand twenty-four</u> shall increase by ten percent.

<u>For any rate year, all reconciliation add-on amounts calculated on and after October first, two thousand twenty-four shall be reduced by twenty percent, and all reconciliation recoupment amounts calculated on or after October first, two thousand twenty-four shall increase by twenty percent.</u>

Notwithstanding any inconsistent provision of subparagraph (i) of paragraph (e) of subdivision nine of this section, capital related inpatient expenses of a general hospital included in the computation of rates of payment based on a budget shall not be included in the computation of a volume adjustment made in accordance with such subparagraph. Adjustments to rates of payment for a general hospital made pursuant to this paragraph shall be made in accordance with paragraph (c) of subdivision eleven of this section. Such adjustments shall not be carried forward except for such volume adjustment as may be authorized in accordance with subparagraph (i) of paragraph (e) of subdivision nine of this section for such general hospital.

§ 2. Section 5 of part ZZ of chapter 56 of the laws of 2020 amending the tax law and the social services law relating to certain Medicaid

management, as amended by section 3 of part RR of chapter 57 of the laws of 2022, is amended to read as follows:

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

§ 3. Section 2 of part E of chapter 57 of the laws of 2015, amending the public health law relating to the payment of certain funds for uncompensated care, is amended to read as follows:

§ 2. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for [periods on and after] each state fiscal year from April 1, 2015, through December 31, 2024; and for the calendar year January 1, 2025 through December 31, 2025; and for each calendar year thereafter, payments pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law may be made as outpatient upper payment limit payments for outpatient hospital services, not to exceed an amount of three hundred thirty-nine million dollars annually between payments authorized under this section and such section of the public health law. Such payments shall be made as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. No eligible general hospital's annual payment amount pursuant to this section shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of the public health law; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law and this section to the total of all payment amounts for such eligible hospitals. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible general hospitals other than major public general hospitals. The distribution of such payments shall be pursuant to a methodology approved by the commissioner of health in regulation.

§ 4. Section 21 of part B of chapter 57 of the laws of 2015, amending the social services law relating to supplemental rebates, is amended to read as follows:

§ 21. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for [the period] each state fiscal year from April 1, 2011 through [March 31, 2012, and state fiscal years] December 31, 2024; and for the calendar year January 1, 2025 through December 31, 2025; and for each calendar year thereafter, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law for public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population over one million, up to two hundred eighty-seven million dollars annually as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on such criteria and methodologies as the commissioner may from time to time set through a memorandum of understanding with the New York city health and hospitals corporation, and such adjustments shall be paid by means of one or more estimated payments, with such estimated payments to be reconciled to the commissioner of health's final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal social security act. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

§ 5. The opening paragraph of subparagraph (i) of paragraph (i) of subdivision 35 of section 2807-c of the public health law, as amended by section 4 of part C of chapter 56 of the laws of 2013, is amended to read as follows:

Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for [the period] each state fiscal year from July first, two thousand ten through [March thirty-first, two thousand eleven,] December thirty-first, two thousand twenty-four; and [each state fiscal year period] for the calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five; and for each calendar year thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven, three hundred fourteen million dollars for each state fiscal year beginning April first, two thousand eleven, through March thirty-first, two thousand thirteen, and no less than three hundred thirty-nine million dollars for each state fiscal year [thereafter] until December thirty-first, two thousand twenty-four; and then from calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five; and for each calendar year thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-ser-

vice and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

§ 6. Section 18 of part B of chapter 57 of the laws of 2015, amending the social services law relating to supplemental rebates, is amended to read as follows:

§ 18. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for [the period] each state fiscal year from April 1, 2012, through [March 31, 2013, and state fiscal years] December 31, 2024; and for the calendar year from January 1, 2025 through December 31, 2025; and for each calendar year thereafter, the department of health is authorized to pay a public hospital adjustment to public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population of over 1 million, of up to one billion eighty million dollars annually as medical assistance payments for inpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on such criteria and methodologies as the commissioner may from time to time set through a memorandum of understanding with the New York city health and hospitals corporation, and such adjustments shall be paid by means of one or more estimated payments, with such estimated payments to be reconciled to the commissioner of health's final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal social security act. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

§ 7. Subdivision 1 of section 3-a of part B of chapter 58 of the laws of 2010, amending the social services law and the public health law relating to prescription drug coverage for needy persons and health care initiatives pools, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for [the period] each state fiscal year from August 1, 2010 through [March 31, 2011, and each state fiscal year] December 31, 2024; and for the calendar year from January 1, 2025 through December 31, 2025; and for each calendar year thereafter, the department of health is authorized to make Medicaid payment increases for diagnostic and treatment centers (DTC) services issued pursuant to section 2807 of the public health law for public DTCs operated by the New York City Health and Hospitals Corporation, at the election of the social services district in which an eligible DTC is physically located, of up to twelve million six hundred thousand dollars on an annualized

basis for DTC services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on each such DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

§ 8. Subdivision 1 of section 3-b of part B of chapter 58 of the laws of 2010, amending the social services law and the public health law relating to prescription drug coverage for needy persons and health care initiatives pools, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for [the period] <u>each state fiscal year from</u> August 1, 2010 through [March 31, 2011, and each state fiscal year] <u>December 31, 2024; and for the calendar year from January 1, 2025 through December 31, 2025; and for each calendar year</u> thereafter, the department of health, is authorized to make Medicaid payment increases for county operated diagnostic and treatment centers (DTC) services issued pursuant to section 2807 of the public health law and for services provided by county operated free-standing clinics licensed pursuant to articles 31 and 32 of the mental hygiene law, but not including facilities operated by the New York City Health and Hospitals Corporation, of up to five million four hundred thousand dollars on an annualized basis for such services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act. Local social services districts may decline such increased payments to their sponsored DTCs and free-standing clinics, provided they provide written notification to the commissioner of health, within thirty days following receipt of notification of a payment pursuant to this section. Distributions pursuant to this section shall be based on each facility's proportionate share of the sum of all DTC and clinic visits for all facilities receiving payments pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates or payment or made as aggregate payments to eligible facilities.

§ 9. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 15 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

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

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

§ 10. This act shall take effect immediately; provided, however, section one of this act shall take effect October 1, 2024; and provided, further, that sections three, four, five, six, seven, eight and nine of this act shall take effect January 1, 2025.

PART E

Section 1. Subparagraph (ii) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(ii) (A) The operating component of rates shall be subject to case mix adjustment through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the federal government with regard to payments to skilled nursing facilities pursuant to title XVIII of the federal social security act (Medicare), as revised by regulation to reflect New York state wages and fringe benefits, provided, however, that such RUG-III classification system weights shall be increased in the following amounts for the following categories of residents: [(A)] (1) thirty minutes for the impaired cognition A category, [(B)] (2) forty minutes for the impaired cognition B category, and [(C)] (3) twenty-five minutes for the reduced physical functions B category. Such adjustments shall be made in January and July of each calendar year. Such adjustments and related patient classifications in each facility shall be subject to audit review in accordance with regulations promulgated by the commissioner.

(B) Effective April first, two thousand twenty-four, the case mix adjustment from the operating component of the rates for skilled nursing facilities shall remain unchanged from the July two thousand twenty-three rates during the development and until full implementation of a case mix methodology using the Patient Driven Payment Model.

§ 2. Subparagraph (iv) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 1 of part NN of chapter 56 of the laws of 2020, is amended to read as follows:

(iv) The capital cost component of rates on and after January first, two thousand nine shall: (A) fully reflect the cost of local property taxes and payments made in lieu of local property taxes, as reported in each facility's cost report submitted for the year two years prior to the rate year; (B) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by five percent; and (C) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty-four for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by an additional ten percent, provided, however, that such reduction shall not apply to rates of payment for patients in pediatric residential health care facilities as defined in paragraph (c) of subdivision two of section twenty-eight hundred eight-e of this article.

§ 3. Paragraph (h) of subdivision 1 of section 2632 of the public health law, as amended by chapter 414 of the laws of 2015, is amended to read as follows:

(h) in the Persian Gulf conflict from the second day of August, nineteen hundred ninety to the end of such conflict including military service in Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn or Operation Inherent Resolve and was the recipient of the global war on terrorism expeditionary medal or the Iraq campaign medal or the Afghanistan campaign medal; and who was a resident of the state of New York at the time of entry upon such active duty or who shall have been a resident of this state for [one year] six months next preceding the application for admission shall be entitled to admission to said home after the approval of the application by the board of visitors, subject to the provisions of this article and to the conditions, limitations and penalties prescribed by the regulations of the department. Any such veteran or dependent, who otherwise fulfills the requirements set forth in this section, may be admitted directly to the skilled nursing facility or the health related facility provided such veteran or dependent is certified by a physician designated or approved by the department to require the type of care provided by such facilities.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART F

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

(n) The commissioner of health is authorized to create a program to subsidize the cost of assisted living for those individuals living with Alzheimer's disease and dementia who are not eligible for medical assistance pursuant to title eleven of article five of this chapter and reside in a special needs assisted living residence certified under section forty-six hundred fifty-five of the public health law. [The] Subject to appropriations, the program shall authorize [up to two hundred] vouchers to individuals through an application process and pay for up to seventy-five percent of the average private pay rate in the respective region. The commissioner of health may propose rules and regulations to effectuate this provision.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART G

Intentionally Omitted

PART H

Section 1. Section 1 of part I of chapter 57 of the laws of 2022, providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, is amended by adding two new subdivisions 3 and 4 to read as follows:

3. For the state fiscal years beginning April 1, 2024, and thereafter, all department of health Medicaid payments made to Medicaid managed care organizations will no longer be subject to the uniform rate increase in subdivision 1 of this section.

4. Rate adjustments made pursuant to subdivisions 1 through 3 of this section shall not be subject to the notification requirements set forth in subdivision 7 of section 2807 of the public health law.

§ 2. This act shall take effect immediately.

PART I

Section 1. Paragraph (a) of subdivision 4 of section 365-a of the social services law, as amended by chapter 493 of the laws of 2010, is amended to read as follows:

(a) drugs which may be dispensed without a prescription as required by section sixty-eight hundred ten of the education law; provided, however, that the state commissioner of health may by regulation specify certain of such drugs which may be reimbursed as an item of medical assistance in accordance with the price schedule established by such commissioner. Notwithstanding any other provision of law, [additions] modifications to the list of drugs reimbursable under this paragraph may be filed as regulations by the commissioner of health without prior notice and comment; provided, however, that the department will notify enrollees of any eliminations to the list of drugs reimbursable under this paragraph at least sixty days prior to the removal of such drug. Such eliminations shall be referred to the drug utilization review board established pursuant to section three hundred sixty-nine-bb of this article for recommendation prior to elimination from the list;

§ 1-a. Subdivision 7 of section 272 of the public health law, as amended by section 16 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

7. The commissioner shall provide thirty days public notice on the department's website prior to any meeting of the board to develop recommendations concerning the preferred drug program and any proposed eliminations to the list of drugs reimbursable under subdivision four of section three hundred sixty-five-a of the social services law. Such notice regarding meetings of the board shall include a description of the proposed therapeutic class to be reviewed, a listing of drug products in the therapeutic class, and the proposals to be considered by the board. The board shall allow interested parties a reasonable opportunity to make an oral presentation to the board related to the prior authorization of the therapeutic class to be reviewed. The board shall consider any information provided by any interested party, including, but not limited to, prescribers, dispensers, patients, consumers and manufacturers of the drug in developing their recommendations.

§ 2. Subdivision 8 of section 272 of the public health law, as amended by section 16 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

8. The commissioner shall provide notice of any recommendations developed by the board regarding the preferred drug program or elimination to the list of drugs reimbursable under subdivision four of section three hundred sixty-five-a of the social services law, at least five days before any final determination by the commissioner, by making such information available on the department's website. Such public notice may include: a summary of the deliberations of the board; a summary of the positions of those making public comments at meetings of the board; the response of the board to those comments, if any; and the findings and recommendations of the board.

§ 3. Subdivision 9 of section 272 of the public health law, as amended by section 16 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

9. Within ten days of a final determination regarding the preferred drug program or elimination to the list of drugs reimbursable under subdivision four of section three hundred sixty-five-a of the social services law, the commissioner shall provide public notice on the department's website of such determinations, including: the nature of the determination; and analysis of the impact of the commissioner's determination on state public health plan populations and providers; and the projected fiscal impact to the state public health plan programs of the commissioner's determination.

§ 4. Section 280 of the public health law, as amended by section 8 of part D of chapter 57 of the laws of 2018, paragraph (b) of subdivision 2 as amended by section 5, subdivision 3 as amended by section 6, paragraph (a) of subdivision 5 as amended by section 7, subparagraph (iii) of paragraph (e) of subdivision 5 as amended by section 6-a and subdivision 8 as amended by section 9 of part B of chapter 57 of the laws of 2019, paragraphs (c) and (d) of subdivision 2 as amended and paragraph (e) of subdivision 2 as added by section 2 of part FFF of chapter 56 of the laws of 2020, the opening paragraph of paragraph (a) of subdivision 6 and paragraph (a) of subdivision 7 as amended by sections 3 and 4, respectively, of part GG of chapter 56 of the laws of 2020, is amended to read as follows:

§ 280. Medicaid drug cap. 1. The legislature hereby finds and declares that there is a significant public interest for the Medicaid program to

manage drug costs in a manner that ensures patient access while providing financial stability for the state and participating providers. Since two thousand eleven, the state has taken significant steps to contain costs in the Medicaid program by imposing a statutory limit on annual growth. Drug expenditures, however, continually outpace other cost components causing significant pressure on the state, providers, and patient access operating under the Medicaid global cap. It is therefore intended that the department establish a [Medicaid drug cap as a separate component within the Medicaid global cap] supplemental rebate program as part of a focused and sustained effort to balance the growth of drug expenditures with the growth of total Medicaid expenditures.

2. The commissioner shall [establish a year to year] review at least annually the department of health state funds Medicaid drug [expenditure growth target as follows:

(a) for state fiscal year two thousand seventeen--two thousand eighteen, be limited to the ten-year rolling average of the medical component of the consumer price index plus five percent and minus a pharmacy savings target of fifty-five million dollars; and

(b) for state fiscal year two thousand eighteen--two thousand nineteen, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars;

(c) for state fiscal year two thousand nineteen--two thousand twenty, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars;

(d) for state fiscal year two thousand twenty--two thousand twenty-one, be limited to the ten-year rolling average of the medical component of the consumer price index plus two percent; and

(e) for state fiscal year two thousand twenty-one--two thousand twenty-two and fiscal years thereafter, be limited in accordance with subdivision one of section ninety-one of part H of chapter fifty-nine of the laws of two thousand eleven, as amended] expenditures to identify drugs in the eightieth percentile or higher of total spend, net of rebate or in the eightieth percentile or higher based on cost per claim, net of rebate.

3. (a) The [department and the division of the budget shall assess on a quarterly basis the projected total amount to be expended in the year on a cash basis by the Medicaid program for each drug, and the projected annual amount of state funds Medicaid drug expenditures on a cash basis for all drugs, which shall be a component of the projected department of health state funds Medicaid expenditures calculated for purposes of sections ninety-one and ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven. For purposes of this section, state funds Medicaid drug expenditures include amounts expended for drugs in both the Medicaid fee-for-service program and Medicaid managed care programs, minus the amount of any drug rebates or supplemental drug rebates received by the department, including rebates pursuant to subdivision five of this section with respect to rebate targets. The department and the division of the budget shall report in December of each year, for the prior April through October, to the drug utilization review board the projected state funds Medicaid drug expenditures including the amounts, in aggregate thereof, attributable to the net cost of: changes in the utilization of drugs by Medicaid recipients; changes in the number of Medicaid recipients; changes to the cost of brand name drugs and changes to the cost of generic drugs. The informa-

tion contained in the report shall not be publicly released in a manner that allows for the identification of an individual drug or manufacturer or that is likely to compromise the financial competitive, or proprietary nature of the information.

(a) In the event the director of the budget determines, based on Medicaid drug expenditures for the previous quarter or other relevant information, that the total department of health state funds Medicaid drug expenditure is projected to exceed the annual growth limitation imposed by subdivision two of this section, the] commissioner may identify and refer drugs in the eightieth percentile or higher of total spend, net of rebate or in the eightieth percentile or higher based on cost per claim, net of rebate, to the drug utilization review board established by section three hundred sixty-nine-bb of the social services law for a recommendation as to whether a target supplemental Medicaid rebate should be paid by the manufacturer of the drug to the department and the target amount of the rebate.

(b) If the department intends to refer a drug to the drug utilization review board pursuant to paragraph (a) of this subdivision, the department shall notify the manufacturer of such drug and shall attempt to reach agreement with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review. Such rebate may be based on evidence-based research, including, but not limited to, such research operated or conducted by or for other state governments, the federal government, the governments of other nations, and third party payers or multi-state coalitions, provided however that the department shall account for the effectiveness of the drug in treating the conditions for which it is prescribed or in improving a patient's health, quality of life, or overall health outcomes, and the likelihood that use of the drug will reduce the need for other medical care, including hospitalization.

(c) In the event that the commissioner and the manufacturer have previously agreed to a supplemental rebate for a drug pursuant to paragraph (b) of this subdivision or paragraph (e) of subdivision seven of section three hundred sixty-seven-a of the social services law, the drug shall not be referred to the drug utilization review board for any further supplemental rebate for the duration of the previous rebate agreement, provided however, the commissioner may refer a drug to the drug utilization review board if the commissioner determines there are significant and substantiated utilization or market changes, new evidence-based research, or statutory or federal regulatory changes that warrant additional rebates. In such cases, the department shall notify the manufacturer and provide evidence of the changes or research that would warrant additional rebates, and shall attempt to reach agreement with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review.

(d) The department shall consider a drug's actual cost to the state, including current rebate amounts, prior to seeking an additional rebate pursuant to paragraph (b) or (c) of this subdivision.

(e) [The commissioner shall be authorized to take the actions described in this section only so long as total Medicaid drug expenditures are projected to exceed the annual growth limitation imposed by subdivision two of this section.] If the commissioner is unsuccessful in entering into a rebate arrangement with the manufacturer of the drug satisfactory to the department, the drug manufacturer shall, in that event be required to provide to the department, on a standard reporting form developed by the department, the following information:

(i) the actual cost of developing, manufacturing, producing (including the cost per dose of production), and distributing the drug;

(ii) research and development costs of the drug, including payments to predecessor entities conducting research and development, such as biotechnology companies, universities and medical schools, and private research institutions;

(iii) administrative, marketing, and advertising costs for the drug, apportioned by marketing activities that are directed to consumers, marketing activities that are directed to prescribers, and the total cost of all marketing and advertising that is directed primarily to consumers and prescribers in New York, including but not limited to prescriber detailing, copayment discount programs, and direct-to-consumer marketing;

(iv) the extent of utilization of the drug;

(v) prices for the drug that are charged to purchasers outside the United States;

(vi) prices charged to typical purchasers in the state, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers, or other direct purchasers;

(vii) the average rebates and discounts provided per payer type in the state; and

(viii) the average profit margin of each drug over the prior five-year period and the projected profit margin anticipated for such drug.

(f) All information disclosed pursuant to paragraph (e) of this subdivision shall be considered confidential and shall not be disclosed by the department in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

4. In determining whether to recommend a target supplemental rebate for a drug, the drug utilization review board shall consider the actual cost of the drug to the Medicaid program, including federal and state rebates, and may consider, among other things:

(a) the drug's impact on [the] Medicaid drug spending [growth target], and the adequacy of capitation rates of participating Medicaid managed care plans, and the drug's affordability and value to the Medicaid program; or

(b) significant and unjustified increases in the price of the drug; or

(c) whether the drug may be priced disproportionately to its therapeutic benefits.

5. (a) If the drug utilization review board recommends a target rebate amount on a drug referred by the commissioner, the department shall negotiate with the drug's manufacturer for a supplemental rebate to be paid by the manufacturer in an amount not to exceed such target rebate amount. [A rebate requirement shall apply beginning with the first day of the state fiscal year during which the rebate was required without regard to the date the department enters into the rebate agreement with the manufacturer.]

(b) The supplemental rebate required by paragraph (a) of this subdivision shall apply to drugs dispensed to enrollees of managed care providers pursuant to section three hundred sixty-four-j of the social services law and to drugs dispensed to Medicaid recipients who are not enrollees of such providers.

(c) [If the drug utilization review board recommends a target rebate amount for a drug and the department is unable to negotiate a rebate from the manufacturer in an amount that is at least seventy-five percent of the target rebate amount, the commissioner is authorized to waive the provisions of paragraph (b) of subdivision three of section two hundred

seventy-three of this article and the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law with respect to such drug; however, this waiver shall not be implemented in situations where it would prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition. Under no circumstances shall the commissioner be authorized to waive such provisions with respect to more than two drugs in a given time.

(d)] Where the department and a manufacturer enter into a rebate agreement pursuant to this section, which may be in addition to existing rebate agreements entered into by the manufacturer with respect to the same drug, no additional rebates shall be required to be paid by the manufacturer to a managed care provider or any of a managed care provider's agents, including but not limited to any pharmacy benefit manager, while the department is collecting the rebate pursuant to this section.

[(e)] (d) In formulating a recommendation concerning a target rebate amount for a drug, the drug utilization review board may consider:

(i) publicly available information relevant to the pricing of the drug;

(ii) information supplied by the department relevant to the pricing of the drug;

(iii) information relating to value-based pricing provided, however, if the department directly invites any third party to provide cost-effectiveness analysis or research related to value-based pricing, and the department receives and considers such analysis or research for use by the board, such third party shall disclose any funding sources. The department shall, if reasonably possible, make publicly available the following documents in its possession that it relies upon to provide cost effectiveness analyses or research related to value-based pricing: (A) descriptions of underlying methodologies; (B) assumptions and limitations of research findings; and (C) if available, data that presents results in a way that reflects different outcomes for affected subpopulations;

(iv) the seriousness and prevalence of the disease or condition that is treated by the drug;

(v) the extent of utilization of the drug;

(vi) the effectiveness of the drug in treating the conditions for which it is prescribed, or in improving a patient's health, quality of life, or overall health outcomes;

(vii) the likelihood that use of the drug will reduce the need for other medical care, including hospitalization;

(viii) the average wholesale price, wholesale acquisition cost, retail price of the drug, and the cost of the drug to the Medicaid program minus rebates received by the state;

(ix) in the case of generic drugs, the number of pharmaceutical manufacturers that produce the drug;

(x) whether there are pharmaceutical equivalents to the drug; and

(xi) information supplied by the manufacturer, if any, explaining the relationship between the pricing of the drug and the cost of development of the drug and/or the therapeutic benefit of the drug, or that is otherwise pertinent to the manufacturer's pricing decision; any such information, including the information on the standard reporting form requirement in paragraph (e) of subdivision three of this section, provided shall be considered confidential and shall not be disclosed by the drug utilization review board in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

6. [(a) If the drug utilization review board recommends a target rebate amount or if the commissioner identifies a drug as a high cost drug pursuant to subparagraph (vii) of paragraph (e) of subdivision 7 of section three hundred sixty-seven-a of the social services law and the department is unsuccessful in entering into a rebate arrangement with the manufacturer of the drug satisfactory to the department, the drug manufacturer shall in that event be required to provide to the department, on a standard reporting form developed by the department, the following information:

(i) the actual cost of developing, manufacturing, producing (including the cost per dose of production), and distributing the drug;

(ii) research and development costs of the drug, including payments to predecessor entities conducting research and development, such as biotechnology companies, universities and medical schools, and private research institutions;

(iii) administrative, marketing, and advertising costs for the drug, apportioned by marketing activities that are directed to consumers, marketing activities that are directed to prescribers, and the total cost of all marketing and advertising that is directed primarily to consumers and prescribers in New York, including but not limited to prescriber detailing, copayment discount programs, and direct-to-consumer marketing;

(iv) the extent of utilization of the drug;

(v) prices for the drug that are charged to purchasers outside the United States;

(vi) prices charged to typical purchasers in the state, including but not limited to pharmacies, pharmacy chains, pharmacy wholesalers, or other direct purchasers;

(vii) the average rebates and discounts provided per payer type in the State; and

(viii) the average profit margin of each drug over the prior five-year period and the projected profit margin anticipated for such drug.

(b) All information disclosed pursuant to paragraph (a) of this subdivision shall be considered confidential and shall not be disclosed by the department in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

7.] (a) [If, after] <u>After</u> taking into account all rebates and supplemental rebates received by the department, including rebates received to date pursuant to this section[, total Medicaid drug expenditures are still projected to exceed the annual growth limitation imposed by subdivision two of this section], the commissioner may: subject any drug of a manufacturer referred to the drug utilization review board under this section to prior approval in accordance with existing processes and procedures when such manufacturer has not entered into a supplemental rebate arrangement as required by this section; direct a managed care plan to limit or reduce reimbursement for a drug provided by a medical practitioner if the drug utilization review board recommends a target rebate amount for such drug and the manufacturer has failed to enter into a rebate arrangement required by this section; direct managed care plans to remove from their Medicaid formularies any drugs of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount for and the manufacturer has failed to enter into a rebate arrangement required by this section; promote the use of cost effective and clinically appropriate drugs other than those of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount and the manufacturer has failed to

enter into a rebate arrangement required by this section; allow manufacturers to accelerate rebate payments under existing rebate contracts; and such other actions as authorized by law. The commissioner shall provide written notice to the legislature at least thirty days prior to taking action pursuant to this paragraph[, unless action is necessary in the fourth quarter of a fiscal year to prevent total Medicaid drug expenditures from exceeding the limitation imposed by subdivision two of this section, in which case such notice to the legislature may be less than thirty days].

(b) The commissioner shall be authorized to take the actions described in paragraph (a) of this subdivision [only so long as total Medicaid drug expenditures are projected to exceed the annual growth limitation imposed by subdivision two of this section]. In addition, no such actions shall be deemed to supersede the provisions of paragraph (b) of subdivision three of section two hundred seventy-three of this article or the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law[, except as allowed by paragraph (c) of subdivision five of this section]; provided further that nothing in this section shall prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition.

[8.] 7. The commissioner shall provide a report by July first annually to the drug utilization review board, the governor, the speaker of the assembly, and the temporary president of the senate on savings achieved through the [drug cap] supplemental rebate programs in the last fiscal year. Such report shall provide data on what savings were achieved through actions pursuant to subdivisions three, five and [seven] six of this section, respectively, and what savings were achieved through other means and how such savings were calculated and implemented.

§ 5. The opening paragraph of paragraph (e) of subdivision 7 of section 367-a of the social services law, as amended by section 24 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

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

Cosmetic Act for drugs approved under Subpart H of 21 CFR Part 314 and Subpart E of 21 CFR Part 601 for serious conditions that fill an unmet medical need based on whether the drug has an effect on a surrogate clinical endpoint, and is pending verification of clinical benefit in confirmatory trials.

§ 6. Paragraphs (a), (b) and (c) of subdivision 9 of section 367-a of the social services law, paragraphs (a) and (c) as amended by chapter 19 of the laws of 1998, paragraph (b) as amended by section 3 of part C of chapter 58 of the laws of 2004, subparagraphs (i) and (ii) of paragraph (b) as amended by section 7 of part D of chapter 57 of the laws of 2017, and subparagraph (iii) of paragraph (b) as added by section 29 of part E of chapter 63 of the laws of 2005, are amended to read as follows:

(a) for drugs provided by medical practitioners and claimed separately by the practitioners[, the actual cost of the drugs to the practitioners; and] the lower of:

(i) (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the actual cost of the drug to the practitioner.

(ii) Notwithstanding subparagraph (i) of this paragraph and paragraph (e) of this subdivision, for the Medicaid fee-for-service program, if a drug has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subdivision (a) of such section that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for purchase under the section 340B program and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this subparagraph. Medical practitioners submitting claims for reimbursement of drugs purchased pursuant to section 340B of the public health service act shall notify the department that the claim is eligible for purchase under the 340B program, consistent with claiming instructions issued by the department to identify such claims.

(iii) In no event shall a medical practitioner be reimbursed at an amount that is lower than the state maximum acquisition cost, or for drugs that do not have a state maximum acquisition cost, the wholesale acquisition cost of the drug based on the package size.

(b) for drugs dispensed by pharmacies:

(i) (A) if the drug dispensed is a generic prescription drug, the lower of: (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount if not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less seventeen and one-half percent thereof; (2) the federal upper

limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the dispensing pharmacy's usual and customary price charged to the general public; (B) if the drug dispensed is available without a prescription as required by section sixty-eight hundred ten of the education law but is reimbursed as an item of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title, the lower of (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost if any, established pursuant to paragraph (e) of this subdivision; or (4) the dispensing pharmacy's usual and customary price charged to the general public;

(ii) if the drug dispensed is a brand-name prescription drug, the lower of:

(A) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department[, less three and three-tenths percent thereof]; or (B) the dispensing pharmacy's usual and customary price charged to the general public; and

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph and paragraphs (d) and (e) of this subdivision, if the drug dispensed is a drug that has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity pursuant to such section, plus the reasonable administrative costs, as determined by the commissioner, incurred by the covered entity or by an authorized contract pharmacy in connection with the purchase and dispensing of such drug and the tracking of such transactions. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subsection (a) of such section, that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for purchase under the section 340B program and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this subparagraph. Pharmacies submitting claims for reimbursement of drugs purchased pursuant to section 340B of the public health service act shall notify the department that the claim is eligible for purchase under the 340B program, consistent with claiming instructions issued by the department to identify such claims.

(c) Notwithstanding subparagraph (i) of paragraph (b) of this subdivision, if a qualified prescriber certifies "brand medically necessary" or "brand necessary" in his or her own handwriting directly on the face of a prescription, or in the case of electronic prescriptions, inserts an electronic direction to clarify "brand medically necessary" or "brand

necessary", for a multiple source drug for which a specific upper limit of reimbursement has been established by the federal agency, in addition to writing "d a w" in the box provided for such purpose on the prescription form, payment under this title for such drug must be made under the provisions of subparagraph (ii) of such paragraph.

§ 7. This act shall take effect October 1, 2024; provided that the amendments to paragraph (e) of subdivision 7 of section 367-a of the social services law made by section five of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; and provided further, that the amendments to subdivision 9 of section 367-a of the social services law made by section six of this act shall not affect the expiration of such subdivision pursuant to section 4 of chapter 19 of the laws of 1998, as amended, and shall expire therewith.

PART J

Section 1. The title heading of title 11-D of article 5 of the social services law, as amended by section 1 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

[BASIC HEALTH PROGRAM] ESSENTIAL PLAN

§ 2. Section 3 of part H of chapter 57 of the laws of 2021, amending the social services law relating to eliminating consumer-paid premium payments in the basic health program, is amended to read as follows:

§ 3. This act shall take effect June 1, 2021 [and]; provided, however, section two of this act shall expire and be deemed repealed should federal approval be withdrawn or 42 U.S.C. 18051 be repealed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the withdrawal of federal approval or the repeal of 42 U.S.C. 18051 in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

§ 3. Subdivisions (b) and (c) of section 8 of part BBB of chapter 56 of the laws of 2022, amending the public health law and other laws relating to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent, are amended to read as follows:

(b) section four of this act shall expire and be deemed repealed December 31, [2024] 2025; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section five of this act shall take effect; provided, however, the amendments to such paragraph made by section five of this act shall expire and be deemed repealed December 31, [2024] 2025;

(c) section six of this act shall take effect January 1, [2025] 2026; provided, however, the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by such section of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 2 of part H of chapter 57 of the laws of 2021 when upon such date, the provisions of section seven of this act shall take effect; and

§ 4. Paragraph (a) of subdivision 1 of section 268-c of the public health law, as added by section 2 of part T of chapter 57 of the laws of 2019, is amended to read as follows:

(a) Perform eligibility determinations for federal and state insurance affordability programs including medical assistance in accordance with section three hundred sixty-six of the social services law, child health plus in accordance with section twenty-five hundred eleven of this chapter, the basic health program in accordance with section three hundred sixty-nine-gg of the social services law, the 1332 state innovation program in accordance with section three hundred sixty-nine-ii of the social services law, premium tax credits and cost-sharing reductions and qualified health plans in accordance with applicable law and other health insurance programs as determined by the commissioner;

§ 5. Subdivision 16 of section 268-c of the public health law, as added by section 2 of part T of chapter 57 of the laws of 2019, is amended to read as follows:

16. In accordance with applicable federal and state law, inform individuals of eligibility requirements for the Medicaid program under title XIX of the social security act and the social services law, the children's health insurance program (CHIP) under title XXI of the social security act and this chapter, the basic health program under section three hundred sixty-nine-gg of the social services law, the 1332 state innovation program in accordance with section three hundred sixty-nine-ii of the social services law, or any applicable state or local public health insurance program and if, through screening of the application by the Marketplace, the Marketplace determines that such individuals are eligible for any such program, enroll such individuals in such program.

§ 6. Section 268-c of the public health law is amended by adding a new subdivision 26 to read as follows:

26. Subject to federal approval if required, the use of state funds and the availability of funds in the 1332 state innovation program fund established pursuant to section ninety-eight-d of the state finance law, the commissioner shall have the authority to establish a program to provide subsidies for the payment of premium or cost sharing or both to assist individuals who are eligible to purchase qualified health plans through the marketplace, or take such other action as appropriate to reduce or eliminate qualified health plan premiums or cost-sharing or both.

§ 7. Subparagraph (i) of paragraph (a) of subdivision 4 of section 268-e of the public health law, as added by section 2 of part T of chapter 57 of the laws of 2019, is amended to read as follows:

(i) An initial determination of eligibility, including:

(A) eligibility to enroll in a qualified health plan;

(B) eligibility for Medicaid;

(C) eligibility for Child Health Plus;

(D) eligibility for the Basic Health Program;

(E) eligibility for the 1332 state innovation program;

(F) the amount of advance payments of the premium tax credit and level of cost-sharing reductions;

[(F)] (G) the amount of any other subsidy that may be available under law; and

[(G)] (H) eligibility for such other health insurance programs as determined by the commissioner; and

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

§ 268. Statement of policy and purposes. The purpose of this title is to codify the establishment of the health benefit exchange in New York, known as NY State of Health, The Official Health Plan Marketplace (Marketplace), in conformance with Executive Order 42 (Cuomo) issued April 12, 2012. The Marketplace shall continue to perform eligibility determinations for federal and state insurance affordability programs including medical assistance in accordance with section three hundred sixty-six of the social services law, child health plus in accordance with section twenty-five hundred eleven of this chapter, the basic health program in accordance with section three hundred sixty-nine-gg of the social services law, the 1332 state innovation program in accordance with section three hundred sixty-nine-ii of the social service law, and premium tax credits and cost-sharing reductions, together with performing eligibility determinations for qualified health plans and such other health insurance programs as determined by the commissioner. The Marketplace shall also facilitate enrollment in insurance affordability programs, qualified health plans and other health insurance programs as determined by the commissioner, the purchase and sale of qualified health plans and/or other or additional health plans certified by the Marketplace pursuant to this title, and shall continue to have the authority to operate a small business health options program ("SHOP") to assist eligible small employers in selecting qualified health plans and/or other or additional health plans certified by the Marketplace and to determine small employer eligibility for purposes of small employer tax credits. It is the intent of the legislature, by codifying the Marketplace in state statute, to continue to promote quality and affordable health coverage and care, reduce the number of uninsured persons, provide a transparent marketplace, educate consumers and assist individuals with access to coverage, premium assistance tax credits and cost-sharing reductions. In addition, the legislature declares the intent that the Marketplace continue to be properly integrated with insurance affordability programs, including Medicaid, child health plus and the basic health program, the 1332 state innovation program, and such other health insurance programs as determined by the commissioner.

§ 9. Subdivision 8 of section 268-a of the public health law, as added by section 1 of part PP of chapter 57 of the laws of 2021, is amended to read as follows:

8. "Insurance affordability program" means Medicaid, child health plus, the basic health program, the 1332 state innovation program, postpartum extended coverage and any other health insurance subsidy program designated as such by the commissioner.

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that section six of this act shall only take effect upon the commissioner of health obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an amended application for a waiver for state innovation pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision 25 of section 268-c of the public health law; and provided, further, that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in section six of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of

section 44 of the legislative law and section 70-b of the public officers law.

PART 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 F of chapter 57 of the laws of 2023, is amended to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and] between July 1, 2023 and June 30, 2024<u>, and between July 1, 2024 and June 30, 2025</u> or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002

and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and] between July 1, 2023 and June 30, 2024<u>, and between July 1, 2024 and June 30, 2025</u> 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 F of chapter 57 of the laws of 2023, is amended to read as follows:

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and] between July 1, 2023 and June 30, 2024<u>, and between July 1, 2024 and June 30, 2025</u> allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [and] between July 1, 2023 and June 30, 2024<u>, and between July</u>

1, 2024 and June 30, 2025 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, to the period July 1, 2016 and June 30, 2017, to the period July 1, 2017 to June 30, 2018, to the period July 1, 2018 to June 30, 2019, to the period July 1, 2019 to June 30, 2020, to the period July 1, 2020 to June 30, 2021, to the period July 1, 2021 to June 30, 2022, to the period July 1, 2022 to June 30, 2023, [and] to the period July 1, 2023 to June 30, 2024, and to the period July 1, 2024 to June 30, 2025.

§ 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 F of chapter 57 of the laws of 2023, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,

during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, during the period July 1, 2018 to June 30, 2019, during the period July 1, 2019 to June 30, 2020, during the period July 1, 2020 to June 30, 2021, during the period July 1, 2021 to June 30, 2022, during the period July 1, 2022 to June 30, 2023, [and] during the period July 1, 2023 to June 30, 2024, and during the period July 1, 2024 to June 30, 2025 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024, or covering the period July 1, 2024 to June 30, 2025 shall notify a covered

physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024<u>, or covering the period July 1, 2024 to June 30, 2025</u> determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,

2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024, or covering the period July 1, 2024 to June 30, 2025 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018, and to the period July 1, 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020, and to the period July 1, 2020 to June 30, 2021, and to the period July 1, 2021 to June 30, 2022, and to the period July 1, 2022 to June 30, 2023, and to the period July 1, 2023 to June 30, 2024, and to the period July 1, 2024 to June 30, 2025 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1,

1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018, and covering the period July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to June 30, 2020, and covering the period July 1, 2020 to June 30, 2021, and covering the period July 1, 2021 to June 30, 2022, and covering the period July 1, 2022 to June 30, 2023 for, and covering the period July 1, 2023 to June 30, 2024, and covering the period July 1, 2024 to June 30, 2025 a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 4 of part F of chapter 57 of the laws of 2023, 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, [2024] 2025; 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, [2024] 2025, 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, [2024] 2025 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians

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

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part F of chapter 57 of the laws of 2023, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, June 15, 2022, June 15, 2023, [and] June 15, 2024<u>, and June 15, 2025</u> the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,

2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023, or July 1, 2023 to June 30, 2024, or July 1, 2024 to June 30, 2025 as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023, or July 1, 2023 to June 30, 2024, or July 1, 2024 to June 30, 2025 as applicable.

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of financial services for the purchase of excess liability insurance coverage for eligible participating physicians and dentists for the policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, as applicable, and the cost of administering the hospital excess liability pool for such applicable policy year, pursuant to the program established in chapter 266 of the laws of 1986, as amended, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, June 15, 2019, June 15, 2020, June 15, 2021, June 15, 2022, June 15, 2023, [and] June 15, 2024, and June 15, 2025 as applicable.

§ 6. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part F of chapter 57 of the laws of 2023, 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-three] twenty-four, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [twenty-three] twenty-four; 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-three] twenty-four exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [twenty-three] twenty-four, 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-three] twenty-four, 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-three] twenty-four 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-three] twenty-four.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART L

Intentionally Omitted

PART M

Section 1. Subparagraph 3 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:

(3) (A) A child [under] between the [age] ages of six and nineteen who is determined eligible for medical assistance under the provisions of this section, shall, consistent with applicable federal requirements, remain eligible for such assistance until [the earlier of:

(i)] the last day of the month which is twelve months following the determination [or redetermination] or renewal of eligibility for such assistance[; or

(ii) the last day of the month in which the child reaches the age of nineteen].

(B) A child under the age of six who is determined eligible for medical assistance under the provisions of this section, shall, consistent with applicable federal requirements, remain continuously eligible for medical assistance coverage until the later of:

(i) the last day of the twelfth month following the determination or renewal of eligibility for such assistance; or

(ii) the last day of the month in which the child reaches the age of six.

§ 2. Subdivision 6 of section 2510 of the public health law is amended by adding a new paragraph (e) to read as follows:

(e) an eligible child under six years of age shall, consistent with applicable federal requirements, remain continuously enrolled until the later of:

(i) the last day of the twelfth month following the date of enrollment or recertification in the child health insurance plan; or

(ii) the last day of the month in which the child reaches the age of six.

§ 3. This act shall take effect January 1, 2025.

PART N

Intentionally Omitted

PART O

Section 1. Subdivision 1 of section 2807-k of the public health law is amended by adding a new paragraph (h) to read as follows:

(h) "Underinsured" shall mean an individual with out of pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income.

§ 2. Subdivision 9 of section 2807-k of the public health law, as amended by section 1 of subpart C of part Y of chapter 57 of the laws of 2023, is amended to read as follows:

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must implement minimum collection policies and procedures approved by the commissioner, utilizing only a uniform financial assistance form developed and provided by the department. All general hospitals that do not participate in the indigent care pool shall also utilize only the uniform financial assistance form and otherwise comply with subdivision nine-a of this section governing the provision of financial assistance and hospital collection procedures.

§ 3. Subdivision 9-a of section 2807-k of the public health law, as added by section 39-a of part A of chapter 57 of the laws of 2006 and paragraph (k) as added by section 43 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

9-a. (a) [As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for] For periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand seven, establish financial aid policies and procedures, in accordance with the provisions of this subdivision, for reducing charges otherwise applicable to low-income individuals without health insurance or underinsured individuals, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts. Immigration status shall not be an eligibility criterion for the purpose of determining financial assistance under this section.

(b) Such reductions from charges for [uninsured] patients with incomes below at least [three] four hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed [the greater of] the amount that would have been paid for the same services [by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services] provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

(i) For patients with incomes [at or] below at least [one] two hundred percent of the federal poverty level, the hospital shall [collect no more than a nominal payment amount, consistent with guidelines established by the commissioner] waive all charges. No nominal payment shall be collected;

(ii) For patients with incomes between at least [one] two hundred [one] percent and [one] up to three hundred [fifty] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases [from the nominal amount described in subparagraph (i) of this paragraph] in equal increments as the income of the patient increases, up to a maximum of [twenty] ten percent of the [greater of the] amount that would have been paid for the same services [by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services] provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of ten percent of the amount that would have been paid pursuant to such patient's insurance cost sharing;

(iii) For patients with incomes between at least [one] three hundred [fifty-one] one percent and [two] four hundred [fifty] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the [twenty] ten percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of [the greater] twenty percent of the amount that would have been paid for the same services [by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services] provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of twenty percent of the amount that would have been paid pursuant to such patient's insurance cost sharing; [and

(iv) For patients with incomes between at least two hundred fifty-one percent and three hundred percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid).

(v) For the purposes of this paragraph, "highest volume payor" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.

(vi) A hospital may implement policies and procedures to permit, but not require, consideration on a case-by-case basis of exceptions to the

requirements described in subparagraphs (i) and (ii) of this paragraph based upon the existence of significant assets owned by the patient that should be taken into account in determining the appropriate payment amount for that patient's care, provided, however, that such proposed policies and procedures shall be subject to the prior review and approval of the commissioner and, if approved, shall be included in the hospital's financial assistance policy established pursuant to this section, and provided further that, if such approval is granted, the maximum amount that may be collected shall not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid). In the event that a general hospital reviews a patient's assets in determining payment adjustments such policies and procedures shall not consider as assets a patient's primary residence, assets held in a tax-deferred or comparable retirement savings account, college savings accounts, or cars used regularly by a patient or immediate family members.

(vii)] (iv) Nothing in this paragraph shall be construed to limit a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified herein and/or to provide greater payment discounts for eligible patients than those required by this paragraph.

(c) Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures [upon request]. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the written notification of patients during the intake and registration process, and during discharge of the patient, and through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and during discharge of the patient, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.

(d) Such policies and procedures shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to

adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the [hospital's] financial assistance policy. The monthly payment under such a plan shall not exceed [ten] five percent of the gross monthly income of the patient[, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments]. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed [the rate for a ninety-day security issued by the United States Department of Treasury, plus .5] two percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.

(e) Such policies and procedures shall permit patients to apply for assistance [within at least ninety days of the date of discharge or date of service and provide at least twenty days for patients to submit a completed application] at any time during the collection process. Such policies and procedures may require that patients seeking payment adjustments provide appropriate financial information and documentation in support of their application, provided, however, that such application process shall not be unduly burdensome or complex. General hospitals shall, upon request, assist patients in understanding the hospital's policies and procedures and in applying for payment adjustments. Application forms shall be printed in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency necessary for effective communication with health care providers, or (ii) spoken by non-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. Such policies and procedures shall require that the hospital issue any denial/approval of such application in writing with information on how to appeal the denial and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first applying for coverage under title XIX of the social security act (medicaid) or another publicly subsidized insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another publicly subsidized insurance program, and upon the patient's cooperation in following the [hospital's] financial assistance application requirements, including the provision of information needed to make a determination on the patient's application in accordance with the hospital's financial assistance policy, provided, however, that this requirement shall not apply to any

patient that would otherwise not qualify for coverage based on their immigration status.

(f) Such policies and procedures shall provide that patients with incomes below [three] four hundred percent of the federal poverty level are deemed presumptively eligible for payment adjustments and shall conform to the requirements set forth in paragraph (b) of this subdivision, provided, however, that nothing in this subdivision shall be interpreted as precluding hospitals from extending such payment adjustments to other patients, either generally or on a case-by-case basis. Such policies and procedures shall provide financial aid for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (42 USC 1395dd), to patients who reside in New York state and for medically necessary hospital services for patients who reside in the hospital's primary service area as determined according to criteria established by the commissioner. In developing such criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. Such criteria shall be made available to the public no less than thirty days prior to the date of implementation and shall, at a minimum:

(i) prohibit a hospital from developing or altering its primary service area in a manner designed to avoid medically underserved communities or communities with high percentages of uninsured residents;

(ii) ensure that every geographic area of the state is included in at least one general hospital's primary service area so that eligible patients may access care and financial assistance; and

(iii) require the hospital to notify the commissioner upon making any change to its primary service area, and to include a description of its primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-l of this article.

(g) Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's primary service area. For patients determined to be eligible for financial aid under the terms of a hospital's financial aid policy, such policies and procedures shall prohibit any limitations on financial aid for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

(h) Such policies and procedures shall prohibit the denial of admission or denial of treatment for services that are reasonably anticipated to be medically necessary because the patient has an unpaid medical bill. Such policies and procedures shall [not permit] prohibit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall require the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. Such policies and procedures shall prohibit the sale of medical debt accumulated pursuant to this section to a third party, unless the third party explicitly purchases such medical debt in order to relieve the debt of the patient. Such policies and procedures shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection

agency obtain the hospital's written consent prior to commencing a legal action. Such policies and procedures shall prohibit a hospital from commencing a legal action related to the recovery of medical debt or unpaid bills against patients with incomes below four hundred percent of the federal poverty level. In any legal action related to the recovery of medical debt or unpaid bills by or on behalf of a hospital, the complaint shall be accompanied by an affidavit by the hospital's chief financial officer stating that based upon the hospital's reasonable effort to determine the patient's income, the patient whom they are taking legal action against does not have an income below four hundred percent of the federal poverty level. Such policies and procedures shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in such policies and procedures, and require the implementation of a mechanism for the general hospital to measure its compliance with such policies and procedures. Such policies and procedures shall require that any collection agency under contract with a general hospital for the collection of debts follow the hospital's financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. Such policies and procedures shall prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services medicaid payment is available.

(i) Reports required to be submitted to the department by each general hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

(i) a report on hospital costs incurred and uncollected amounts in providing services to eligible patients without insurance[, including the amount of care provided for a nominal payment amount,] during the period covered by the report;

(ii) hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;

(iii) the number of patients, organized according to United States postal service zip code, who applied for financial assistance pursuant to the hospital's financial assistance policy, and the number, organized according to United States postal service zip code, whose applications were approved and whose applications were denied;

(iv) the number of patients, including their age, race, ethnicity, gender and insurance status, who applied for financial assistance under the hospital's financial assistance policy, and the number of patients, including their age, race, ethnicity, gender and insurance status, whose applications were approved and denied;

(v) the reimbursement received for indigent care from the pool established pursuant to this section;

[(v)] (vi) the amount of funds that have been expended on charity care from charitable bequests made or trusts established for the purpose of providing financial assistance to patients who are eligible in accordance with the terms of such bequests or trusts;

[(vi)] (vii) for hospitals located in social services districts in which the district allows hospitals to assist patients with such applications, the number of applications for eligibility under title XIX of the social security act (medicaid) that the hospital assisted patients in completing and the number denied and approved; and

[(vii)] (viii) the hospital's financial losses resulting from services provided under medicaid[; and

(viii) the number of liens placed on the primary residences of patients through the collection process used by a hospital].

(j) Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material which is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility.

(k) [In the event it is determined by the commissioner that the state will be unable to secure all necessary federal approvals to include, as part of the state's approved state plan under title nineteen of the federal social security act, a requirement, as set forth in paragraph one of this subdivision, that compliance with this subdivision is a condition of participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article, then such condition of participation shall be deemed null and void and, notwithstanding] Notwithstanding section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for a civil penalty not to exceed ten thousand dollars for each such violation. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

(l) A hospital or its collection agent shall not commence a civil action against a patient or delegate a collection activity to a debt collector for nonpayment for at least one hundred eighty days after the first post-service bill is issued and until a hospital has made reasonable efforts to determine whether a patient qualifies for financial assistance.

§ 4. The public health law is amended by adding a new section 18-c to read as follows:

§ 18-c. Separate patient consent for treatment and payment for health care services. Informed consent from a patient to provide any treatment, procedure, examination or other direct health care services shall be obtained separately from such patient's consent to pay for the services. Consent to pay for any health care services by a patient shall not be given prior to the patient receiving such services and discussing treatment costs. For purposes of this section, "consent" means an action which: (a) clearly and conspicuously communicates the individual's authorization of an act or practice; (b) is made in the absence of any mechanism in the user interface that has the purpose or substantial effect of obscuring, subverting, or impairing decision-making or choice to obtain consent; and (c) cannot be inferred from inaction.

§ 5. The general business law is amended by adding two new sections 349-g and 519-a to read as follows:

§ 349-g. Restrictions on applications for and use of credit cards and medical financial products. 1. For purposes of this section, the following terms shall have the following meanings:

(a) "Medical financial products" shall mean medical credit cards and third-party medical installment loans.

(b) "Health care provider" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.

(c) "Medical credit card" shall mean a credit card issued under an open-end or closed-end plan offered specifically for the payment of health care services, products, or devices provided to a person.

2. It shall be prohibited for any hospital or health care provider, or employee or agent of a hospital or health care provider, to complete any portion of an application for medical financial products for the patient or otherwise arrange for or establish an application that is not completely filled out by the patient.

§ 519-a. Credit cards and payment for health care services. 1. For purposes of this section, the term "credit card" shall have the same meaning as in section five hundred eleven of this article.

2. No hospital or health care provider shall require credit card preauthorization nor require the patient to have a credit card on file prior to providing emergency or medically necessary medical services to such patient.

3. Hospitals and health care providers shall notify all patients about the risks of paying for medical services with a credit card. Such notification shall highlight the fact that by using a credit card to pay for medical services, the patient is forgoing state and federal protections that regard medical debt. The commissioner of health shall have the authority and sole discretion to set requirements for the contents of such notices.

§ 6. This act shall take effect six months after it shall have become a law; provided, however, that if section 1 of subpart C of part Y of chapter 57 of the laws of 2023 shall not have taken effect on or before such date then section two of this act shall take effect on the same date and in the same manner as such chapter of the laws of 2023 takes effect. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART P

Section 1. Section 8 of part C of chapter 57 of the laws of 2022 amending the public health law and the education law relating to allowing pharmacists to direct limited service laboratories and order and administer COVID-19 and influenza tests and modernizing nurse practitioners, is amended to read as follows:

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, that sections one, two, three, four, six and seven of this act shall expire and be deemed repealed [two years after it shall have become a law] July 1, 2026.

§ 2. Section 5 of chapter 21 of the laws of 2011 amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, as amended

by section 5 of part CC of chapter 57 of the laws of 2022, is amended to read as follows:

§ 5. This act shall take effect on the one hundred twentieth day after it shall have become a law, provided, however, that the provisions of sections two, three, and four of this act shall expire and be deemed repealed July 1, [2024] 2026; provided, however, that the amendments to subdivision 1 of section 6801 of the education law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 8 of chapter 563 of the laws of 2008, when upon such date the provisions of section one-a of this act shall take effect; provided, further, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART Q

Intentionally Omitted

PART R

Intentionally Omitted

PART S

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

§ 2825-i. Healthcare safety net transformation program. 1. (a) A statewide healthcare safety net transformation program shall be established within the department for the purpose of supporting the transformation of safety net hospitals to improve access, equity, quality, and outcomes while increasing the financial sustainability of safety net hospitals. Such program may provide or utilize new or existing capital funding, or operating subsidies, or both. Any application for this program must be jointly submitted by a safety net hospital and at least one partner organization.

(b) All applications shall demonstrate how the requested funding and regulatory flexibilities are necessary to achieve the program goals of improving the safety net hospital's financial outlook and improving health outcomes for the communities it serves. The commissioner shall develop an application for this program that includes but is not limited to the following information:

(i) key organizational information, including the organizational structure of the safety net hospital and partner organization (including any parent or subsidiary, and the interrelationship between all such organizations) and the name, business address, and biography of each director and officer of the safety net hospital, the partner, and other organizations within either the safety net hospital's or the partner's organizational structure;

(ii) the type of collaborative model proposed, including but not limited to a merger, acquisition, management services contract, or clinical integration;

(iii) a detailed description of the proposed transformation plan that includes, at a minimum, a five-year strategic and operational plan outlining the roles and responsibilities of the safety net hospital and partner organization;

(iv) a timeline of key metrics and goals;

(v) any regulatory flexibilities required to implement such plan, including the justification for why such flexibilities are necessary for the transformation plan to achieve an improved financial outlook for the safety net hospital and improved health outcomes for the communities it serves;

(vi) the amount of funding requested for the first five years and projected needs thereafter, including the rationale for why such funding is necessary for the transformation plan to achieve an improved financial outlook for the safety net hospital and improved health outcomes for the communities it serves; and

(vii) detailed plans for any operational surplus after reaching financial sustainability.

2. The commissioner shall enter an agreement with the president of the dormitory authority of the state of New York pursuant to section sixteen hundred eighty-r of the public authorities law, as required, which shall apply to this agreement, subject to the approval of the director of the division of the budget, for the purposes of the distribution and administration of available funds pursuant to such agreement and made available pursuant to this section and subject to appropriation. Such funds may be awarded and distributed by the department to safety net hospitals, or a partner organization, in the form of grants. To qualify as a safety net hospital for purposes of this section, a hospital shall:

(a) be either a public hospital, a rural emergency hospital, critical access hospital or sole community hospital;

(b) have at least thirty percent of its inpatient discharges made up of medical assistance program eligible individuals, uninsured individuals or medical assistance program dually eligible individuals and at least thirty-five percent of its outpatient visits made up of medical assistance program eligible individuals, uninsured individuals or medical assistance program dually-eligible individuals;

(c) serve at least thirty percent of the residents of a county or a multi-county area who are medical assistance program eligible individuals, uninsured individuals or medical assistance program dually-eligible individuals; or

(d) in the discretion of the commissioner, serve a significant population of medical assistance program eligible individuals, uninsured individuals or medical assistance program dually-eligible individuals.

3. Partner organizations may include, but are not limited to, health systems, hospitals, health plans, residential health care facilities, physician groups, community-based organization, or other healthcare entities who can serve as partners in the transformation of the safety net hospital.

4. Notwithstanding section one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law or any inconsistent provisions of law to the contrary, awards may be provided without a competitive bid or request for proposal process to safety net hospitals or partner organizations for purposes of increasing access, equity, quality, outcomes, and long-term financial sustainability of such safety net hospitals.

5. Notwithstanding any provision of law to the contrary, the commissioner may waive regulatory requirements to allow applicants to more

effectively or efficiently implement projects awarded through the healthcare safety net transformation program, provided, however, that regulations pertaining to minimum standards for hospitals for patient safety, patient autonomy, patient privacy, patient rights, quality of care, safe staffing, adverse event reporting, due process, scope of practice, professional licensure, environmental protections, infection control, provider reimbursement methodologies, character and competence, or occupational standards and employee rights shall not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time periods as the commissioner may determine. Any regulatory relief granted pursuant to this subdivision shall be specifically described and requested within each project application and be reviewed by the commissioner.

6. Continued support under the program shall be contingent upon the implementation of the approved plan and key milestones.

7. The release of any funding will be contingent upon compliance with the transformation plan and a determination that acceptable progress has been made with such plan. If key milestones and goals are not met, additional financial resources may be withheld and redirected, upon the recommendation of the commissioner and approval by the director of budget.

8. The commissioner shall provide a report on an annual basis to the speaker of the assembly, the temporary president of the senate, the chair of the assembly ways and means committee, the chair of the senate finance committee, and the director of the division of budget, on any transformation plan approved under this section, including information on partnership agreements, and any amendments thereto. The report shall also include for each award, the name of the hospital and partner, the corporate structure of any partner organization, a description of the project and its purpose, the amount of the award and the disbursement date, the regulations waived for each project and the justification for such waiver, and the status of achievement of performance metrics and milestones. Such report shall be provided until such time as the department determines that the projects that receive funding pursuant to this section are substantially complete.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART T

Intentionally Omitted

PART U

Intentionally Omitted

PART V

Intentionally Omitted

PART W

Intentionally Omitted

PART X

Intentionally Omitted.

PART Y

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

§ 7. This act shall take effect immediately and shall expire March 31, [2024] 2027 when upon such date the provisions of this act shall be deemed repealed.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART Z

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

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [2024] 2025.

§ 2. This act shall take effect immediately.

PART AA

Section 1. Paragraph 31 of subsection (i) of section 3216 of the insurance law is amended by adding a new subparagraph (J) to read as follows:

(J) This subparagraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of

premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

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

(K) This subparagraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such a facility shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

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

(K) This subparagraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such a facility shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guid-

ance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

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

(J) This subparagraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the insurer and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this subparagraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of premium rate filings and applications, the superintendent shall provide insurers with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, insurers may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

§ 5. Subsection (g) of section 4303 of the insurance law is amended by adding a new paragraph 12 to read as follows:

(12) This paragraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the corporation's provider network. Reimbursement for covered outpatient treatment provided by such facility shall be at rates negotiated between the corporation and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this paragraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of premium rate filings and applications, the superintendent shall provide corporations with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the

extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, corporations may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

§ 6. Subsection (l) of section 4303 of the insurance law is amended by adding a new paragraph 10 to read as follows:

(10) This paragraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at rates negotiated between the corporation and the participating facility, provided that such rates are not less than the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law. For the purposes of this paragraph, the rates that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law shall be the rates with an effective date of April first of the preceding year, which shall be established prior to October first of the preceding calendar year. Prior to the submission of premium rate filings and applications, the superintendent shall provide corporations with guidance on factors to consider in calculating the impact of rate changes for the purposes of submitting premium rate filings and applications to the superintendent for the subsequent policy year. To the extent that the rates with an effective date of April first differ from the estimated rates incorporated in premium rate filings and applications, corporations may account for such differences in future premium rate filings and applications submitted to the superintendent for approval.

§ 7. This act shall take effect January 1, 2025 and shall apply to policies and contracts issued, renewed, modified, altered, or amended on and after such date.

PART BB

Section 1. Sections 19 and 21 of chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, as amended by section 1 of part PPP of chapter 58 of the laws of 2020, are amended to read as follows:

§ 19. Notwithstanding any other provision of law, the commissioner of mental health shall, until July 1, [2024] 2027, be solely authorized, in [his or her] such commissioner's discretion, to designate those general hospitals, local governmental units and voluntary agencies which may apply and be considered for the approval and issuance of an operating certificate pursuant to article 31 of the mental hygiene law for the operation of a comprehensive psychiatric emergency program.

§ 21. This act shall take effect immediately, and sections one, two and four through twenty of this act shall remain in full force and effect, until July 1, [2024] 2027, at which time the amendments and additions made by such sections of this act shall be deemed to be repealed, and any provision of law amended by any of such sections of this act shall revert to its text as it existed prior to the effective date of this act.

§ 2. This act shall take effect immediately.

PART CC

Intentionally Omitted

PART DD

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

§ 3. This act shall take effect immediately; and shall expire and be deemed repealed June 30, [2024] 2027.

§ 2. This act shall take effect immediately.

PART EE

Intentionally Omitted

PART FF

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners of the office of mental health, office for people with developmental disabilities, office of addiction services and supports, office of temporary and disability assistance, office of children and family services, and the state office for the aging (hereinafter "the commissioners") shall establish a state fiscal year 2024-2025 cost of living adjustment (COLA), effective April 1, 2024, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in subdivision five of this section. The COLA established herein shall be applied to the appropriate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the department of health (DOH) shall be made as reimbursement for the state share of medical assistance.

2. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefore, for the period of April 1, 2024 through March 31, 2025, the commissioners shall provide funding to support a two and eight-tenths and four-hundredths percent (2.84%) cost of living adjustment under this section for all eligible programs and services as determined pursuant to subdivision five of this section.

3. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 2.84 percent cost of living adjustment (COLA) established herein shall be inclusive of all other cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2024. Except for the 2.84 percent cost of living adjustment (COLA) established herein, for the period commencing on April 1, 2024 and ending March 31, 2025 the commissioners shall not apply any other new cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other cost of living type increases, inflation factors, or trend factors" as defined in this subdivision

shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic public health emergency. This subdivision shall not prevent the office of children and family services from applying additional trend factors or staff retention factors to eligible programs and services under paragraph (v) of subdivision five of this section.

4. Each local government unit or direct contract provider receiving the cost of living adjustment established herein shall use such funding to provide a targeted salary increase of at least one and seven-tenths percent (1.7%) to eligible individuals in accordance with subdivision six of this section. Notwithstanding any inconsistent provision of law, the commissioners shall develop guidelines for local government units and direct contract providers on implementation of such targeted salary increase.

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

(ii) Programs and services funded, licensed, or certified by the office for people with developmental disabilities (OPWDD) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: local/unified services; chapter 620 services; voluntary operated community residential services; article 16 clinics; day treatment services; family support services; 100% day training; epilepsy services; traumatic brain injury services; hepatitis B services; independent practitioner services for individuals with intellectual and/or developmental disabilities; crisis services for individuals with intellectual and/or developmental disabilities; family

care residential habilitation; supervised residential habilitation; supportive residential habilitation; respite; day habilitation; prevocational services; supported employment; community habilitation; intermediate care facility day and residential services; specialty hospital; pathways to employment; intensive behavioral services; community transition services; family education and training; fiscal intermediary; support broker; and personal resource accounts.

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

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

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

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

6. Eligible individuals. Support staff, direct care staff, clinical staff, and non-executive administrative staff in programs and services

listed in subdivision five of this section shall be eligible for the 1.7% targeted salary increase established pursuant to subdivision four of this section.

(a) For the office of mental health, office for people with developmental disabilities, and office of addiction services and supports, support staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 100 to 199; direct care staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 200 to 299; clinical staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 300 to 399; and non-executive administrative staff shall mean individuals employed in consolidated fiscal report position title codes 400, 500 to 599, 605 to 699, and 703 to 799. Individuals employed in consolidated fiscal report position title codes 601 to 604, 701 and 702 shall be ineligible for the 1.7% targeted salary increase established herein.

(b) For the office of temporary and disability assistance, office of children and family services, and the state office for the aging, eligible support staff, direct care staff, clinical staff, and non-executive administrative staff titles shall be determined by each agency's commissioner.

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

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

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART GG

Section 1. Subdivision 29 of section 364-j of the social services law, as added by section 49 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

29. In the event that the department receives approval from the Centers for Medicare and Medicaid Services to amend its 1115 waiver [known as the Partnership Plan] or receives approval for a new 1115 waiver [for the purpose of reinvesting savings resulting from the redesign of the medical assistance program] <u>prior to or following the effective date of the chapter of the laws of two thousand twenty-four that amended this subdivision</u>, the commissioner is authorized to enter into contracts[, and/or] <u>and</u> to amend the terms of contracts awarded prior to the effective date of <u>the chapter of the laws of two thousand twenty-four that amended</u> this subdivision, for the purpose of assisting the

department of health with implementing projects authorized under such waiver approval. Notwithstanding the provisions of sections one hundred twelve and one hundred sixty-three of the state finance law, or sections one hundred forty-two and one hundred forty-three of the economic development law, or any contrary provision of law, contracts may be entered or contract amendments may be made pursuant to this subdivision until March thirty-first, two thousand twenty-seven without a competitive bid or request for proposal process [if the term of any such contract or contract amendment does not extend beyond March thirty-first, two thousand nineteen]; provided, however, in the case of a contract entered into after the effective date of this subdivision, that:

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

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

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

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

(iv) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

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

(c) The commissioner of health shall select such contractor or contractors that, in [his or her] such commissioner's discretion, are best suited to serve the purposes of this section.

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

PART HH

Section 1. Subparagraphs (i) and (ii) of paragraph (a) of subdivision 4-a of section 365-f of the social services law, as amended by section 3 of part G of chapter 57 of the laws of 2019, the opening paragraph of subparagraph (i) as amended by section 2 of part PP of chapter 57 of the laws of 2022, are amended, and three new subparagraphs (ii-a), (ii-b) and (ii-c) are added to read as follows:

(i) "[Fiscal] Statewide fiscal intermediary" means an entity that provides fiscal intermediary services and has a contract for providing such services with the department of health and is selected through the procurement process described in [paragraphs] paragraph (b)[, (b-1), (b-2) and (b-3)] of this subdivision. [Eligible applicants for contracts shall be entities that are capable of appropriately providing fiscal intermediary services, performing the responsibilities of a fiscal intermediary, and complying with this section, including but not limited to entities that:

(A) are a service center for independent living under section one thousand one hundred twenty-one of the education law; or

(B) have been established as fiscal intermediaries prior to January first, two thousand twelve and have been continuously providing such services for eligible individuals under this section.]

(ii) Fiscal intermediary services shall include the following services, performed on behalf of the consumer to facilitate [his or her] the consumer's role as the employer:

(A) wage and benefit processing for consumer directed personal assistants;

(B) processing all income tax and other required wage withholdings;

(C) complying with workers' compensation, disability and unemployment requirements;

(D) maintaining personnel records for each consumer directed personal assistant, including time records and other documentation needed for wages and benefit processing and a copy of the medical documentation required pursuant to regulations established by the commissioner;

(E) ensuring that the health status of each consumer directed personal assistant is assessed prior to service delivery pursuant to regulations issued by the commissioner;

(F) maintaining records of service authorizations or reauthorizations;

(G) monitoring the consumer's or, if applicable, the designated representative's continuing ability to fulfill the consumer's responsibilities under the program and promptly notifying the authorizing entity of any circumstance that may affect the consumer's or, if applicable, the designated representative's ability to fulfill such responsibilities;

(H) complying with regulations established by the commissioner specifying the responsibilities of fiscal intermediaries providing services under this title;

(I) entering into a department approved memorandum of understanding with the consumer that describes the parties' responsibilities under this program; and

(J) other related responsibilities which may include, as determined by the commissioner, assisting consumers to perform the consumers' responsibilities under this section and department regulations in a manner that does not infringe upon the consumer's responsibilities and self-direction.

(ii-a) The commissioner shall require any managed care plans, managed long-term care plans, local social service districts, and other appropriate long-term service programs offering consumer directed personal assistance services to contract with the statewide fiscal intermediary set forth in subparagraph (i) of this paragraph to provide all fiscal intermediary services to consumers.

(ii-b) The statewide fiscal intermediary shall subcontract to facilitate the delivery of fiscal intermediary services to an entity that is a service center for independent living under section one thousand one hundred twenty-one of the education law that has been providing fiscal intermediary services since January first, two thousand twenty-four or earlier. The statewide fiscal intermediary shall further subcontract to facilitate the delivery of fiscal intermediary services with at least one entity per rate setting region that has a proven record of delivering services to individuals with disabilities and the senior population, and has been providing fiscal intermediary services since January first, two thousand twelve; provided that such subcontractor shall be required to provide any delegated fiscal intermediary services with cultural and linguistic competency specific to the population of consumers and those of the available workforce, and shall comply with the requirements for registration as a fiscal intermediary set forth in subdivision four-a-one of this section. For purposes of this section, "delegated fiscal intermediary services" are defined as fiscal intermediary services as set forth in subparagraph (ii) of paragraph (a) of this subdivision that

the statewide fiscal intermediary includes in a subcontract and which shall include services designed to meet the needs of consumers of the program, which may include assisting consumers with navigation of the program by providing individual consumer assistance and support as needed, consumer peer support, and education and training to consumers on their duties under the program.

(ii-c) The statewide fiscal intermediary shall be responsible for payment to subcontractors for delegated fiscal intermediary services. The payment shall not require a certification by the commissioner if payments are reasonably related to the costs of efficient delivery of such services.

§ 2. Paragraph (b) of subdivision 4-a of section 365-f of the social services law, as amended by section 4 of part G of chapter 57 of the laws of 2019 and subparagraph (vi) as amended by section 1 of part LL of chapter 57 of the laws of 2021, is amended to read as follows:

(b) Notwithstanding [any inconsistent provision of] section one hundred sixty-three of the state finance law, section one hundred twelve of the state finance law, or section one hundred forty-two of the economic development law the commissioner shall enter into [contracts] a contract under this subdivision with an eligible [contractors] contractor that [submit] submits an offer for a contract, provided, however, that:

(i) the department shall post on its website:

(A) a description of the proposed statewide fiscal intermediary services to be provided pursuant to [contracts] a contract in accordance with this subdivision;

(B) [that the selection of contractors shall be based on criteria reasonably related to the contractors' ability to provide fiscal intermediary services including but not limited to: ability to appropriately serve individuals participating in the program, geographic distribution that would ensure access in rural and underserved areas, demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce, ability to provide timely consumer assistance, experience serving individuals with disabilities, the availability of consumer peer support, and demonstrated compliance with all applicable federal and state laws and regulations, including but not limited to those relating to wages and labor] the criteria for selection of the statewide fiscal intermediary, which shall include at a minimum that the eligible contractor is capable of performing statewide fiscal intermediary services with demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce, has experience serving individuals with disabilities, and as of April first, two thousand twenty-four is providing services as a fiscal intermediary on a statewide basis with at least one other state;

(C) the manner by which prospective contractors may seek such selection, which may include submission by electronic means;

(ii) all [reasonable and responsive] offers that are received from prospective contractors in a timely fashion and that meet the criteria set forth in clause (B) of subparagraph (i) of this paragraph shall be reviewed by the commissioner; and

(iii) the commissioner shall award such [contracts] contract to the [contractors] contractor that [best meet] meets the criteria for selection and [are best suited to serve the purposes of] offers the best value for providing the services required pursuant to this section and the needs of consumers[;

(iv) all entities providing fiscal intermediary services on or before April first, two thousand nineteen, shall submit an offer for a contract under this section within sixty days after the commissioner publishes the initial offer on the department's website. Such entities shall be deemed authorized to provide such services unless: (A) the entity fails to submit an offer for a contract under this section within the sixty days; or (B) the entity's offer for a contract under this section is denied;

(v) all decisions made and approaches taken pursuant to this paragraph shall be documented in a procurement record as defined in section one hundred sixty-three of the state finance law; and

(vi) the commissioner is authorized to either reoffer contracts or utilize the previous offer, to ensure that all provisions of this section are met].

§ 3. Section 365-f of the social services law is amended by adding a new subdivision 4-a-1 to read as follows:

4-a-1. (a) Fiscal intermediary registration. Except for the statewide fiscal intermediary and its subcontractors, as of April first, two thousand twenty-five, no entity shall provide, directly or through contract, fiscal intermediary services. All subcontractors of the statewide fiscal intermediary, shall register with the department within thirty days of being selected as a subcontractor.

(b) In selecting its subcontractors, the statewide fiscal intermediary shall consider demonstrated compliance with all applicable federal and state laws and regulations, including but not limited to, marketing and labor practices, cost reporting, and electronic visit verification requirements.

§ 4. Paragraphs (b-1), (b-2) and (b-3) of subdivision 4-a of section 365-f of the social services law are REPEALED.

§ 5. Subdivision 4-b of section 365-f of the social services law, as amended by section 8 of part G of chapter 57 of the laws of 2019, is amended to read as follows:

4-b. Actions involving the [authorization] registration of a fiscal intermediary.

(a) [The department may terminate a fiscal intermediary's contract under this section or suspend or limit the fiscal intermediary's rights and privileges under the contract upon thirty day's written notice to the fiscal intermediary, if the commissioner finds that the fiscal intermediary has failed to comply with the provisions of this section or regulations promulgated hereunder. The written notice shall include:

(i) A description of the conduct and the issues related thereto that have been identified as failure of compliance; and

(ii) the time frame of the conduct that fails compliance] A fiscal intermediary's registration may be revoked, suspended, limited, or annulled by the commissioner upon thirty days' written notice to the fiscal intermediary, if the commissioner finds that the fiscal intermediary has failed to comply with the provisions of this section or regulations promulgated hereunder.

(b) [Notwithstanding the foregoing, upon determining that the public health or safety would be imminently endangered by the continued operation or actions of the fiscal intermediary, the commissioner may terminate the fiscal intermediary's contract or suspend or limit the fiscal intermediary's rights and privileges under the contract immediately upon written notice.] The commissioner may issue orders and take other actions as necessary and appropriate to prohibit and prevent the provision of fiscal intermediary services by an unregistered entity.

(c) All orders or determinations under this subdivision shall be subject to review as provided in article seventy-eight of the civil practice law and rules.

§ 6. Paragraph (d) of subdivision 4-d of section 365-f of the social services law is REPEALED.

§ 7. Paragraph (b) of subdivision 5 of section 365-f of the social services law, as added by chapter 81 of the laws of 1995, is amended to read as follows:

(b) Notwithstanding any other provision of law, the commissioner is authorized to waive any provision of section three hundred sixty-seven-b of this title related to payment and may promulgate regulations necessary to carry out the objectives of the program including minimum safety, and health and immunization criteria and training requirements for personal assistants, and which describe the responsibilities of the eligible individuals in arranging and paying for services and the protections assured such individuals if they are unable or no longer desire to continue in the program, the fiscal intermediary registration process, standards, and time frames, and those regulations necessary to ensure adequate access to services.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART II

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

§ 2807-ff. New York managed care organization provider tax. 1. The commissioner, subject to the approval of the director of the budget, shall: apply for a waiver or waivers of the broad-based and uniformity requirements related to the establishment of a New York managed care organization provider tax (the "MCO provider tax") in order to secure federal financial participation for the costs of the medical assistance program; issue regulations to implement the MCO provider tax; and, subject to approval by the centers for medicare and medicaid services, impose the MCO provider tax as an assessment upon insurers, health maintenance organizations, and managed care organizations offering the following plans or products:

(a) Medical assistance program coverage provided by managed care providers pursuant to section three hundred sixty-four-j of the social services law;

(b) A child health insurance plan certified pursuant to section twenty-five hundred eleven of this chapter;

(c) Essential plan coverage certified pursuant to section three hundred sixty-nine-gg of the social services law;

(d) Coverage purchased on the New York insurance exchange established pursuant to section two hundred sixty-eight-b of this chapter; or

(e) Any other comprehensive coverage subject to articles thirty-two, forty-two and forty-three of the insurance law, or article forty-four of this chapter.

2. The MCO provider tax shall comply with all relevant provisions of federal laws, rules and regulations.

§ 2. The state finance law is amended by adding a new section 99-rr to read as follows:

§ 99-rr. Healthcare stability fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxa-

tion and finance a special fund to be known as the "healthcare stability fund" ("fund").

2. The fund shall consist of monies received from the imposition of the centers for medicare and medicaid services-approved MCO provider tax established pursuant to section twenty-eight hundred seven-ff of the public health law, and all other monies appropriated, credited, or transferred thereto from any other fund or source pursuant to law.

3. Notwithstanding any provision of law to the contrary and subject to available legislative appropriation and approval of the director of the budget, monies of the fund may be available for:

(a) funding the non-federal share of increased capitation payments to managed care providers, as defined in section three hundred sixty-four-j of the social services law, for the medical assistance program, pursuant to a plan developed and approved by the director of the budget;

(b) funding the non-federal share of the medical assistance program, including supplemental support for the delivery of health care services to medical assistance program enrollees and quality incentive programs;

(c) reimbursement to the general fund for expenditures incurred in the medical assistance program, including, but not limited to, reimbursement pursuant to a savings allocation plan established in accordance with section ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven, as amended; and

(d) transfer to the capital projects fund, or any other capital projects fund of the state to support the delivery of health care services.

4. Monies disbursed from the fund shall be exempt from the calculation of department of health state funds medicaid expenditures under subdivision one of section ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven, as amended.

5. Monies in such fund shall be kept separate from and shall not be commingled with any other monies in the custody of the comptroller or the commissioner of taxation and finance. Any monies of the fund not required for immediate use may, at the discretion of the comptroller, in consultation with the director of the budget, be invested by the comptroller in obligations of the United States or the state. Any income earned by the investment of such monies shall be added to and become a part of and shall be used for the purposes of such fund.

6. The director of the budget shall provide quarterly reports to the speaker of the assembly, the temporary president of the senate, the chair of the senate finance committee and the chair of the assembly ways and means committee, on the receipts and distributions of the healthcare stability fund, including an itemization of such receipts and disbursements, the historical and projected expenditures, and the projected fund balance.

§ 3. Paragraphs (g) and (h) of subdivision 1 of section 2807-y of the public health law, as added by section 67 of part B of chapter 58 of the laws of 2005, are amended and a new paragraph (i) is added to read as follows:

(g) section thirty-six hundred fourteen-a of this chapter; [and]

(h) section three hundred sixty-seven-i of the social services law[.]; and

(i) section twenty-eight hundred seven-ff of this article.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

PART JJ

Section 1. Subdivision 3 of section 364-j of the social services law is amended by adding a new paragraph (d-3) to read as follows:

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

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

PART KK

Section 1. Paragraph (d) of subdivision 4 of section 206 of the public health law, as added by chapter 602 of the laws of 2007, is amended and a new paragraph (e) is added to read as follows:

(d) assess civil penalties against a public water system which provides water to the public for human consumption through pipes or other constructed conveyances, as further defined in the state sanitary code or, in the case of mass gatherings, the person who holds or promotes the mass gathering as defined in subdivision five of section two hundred twenty-five of this article not to exceed twenty-five thousand dollars per day, for each violation of or failure to comply with any term or provision of the state sanitary code as it relates to public water systems that serve a population of five thousand or more persons or any mass gatherings, which penalty may be assessed after a hearing or an opportunity to be heard[.]*;*

(e) issue a non-patient specific statewide standing order for the provision of doula services for pregnant, birthing, and postpartum individuals through twelve months postpartum.

§ 2. Article 25 of the public health law is amended by adding a new title 3-A to read as follows:

TITLE III-A

COMMUNITY DOULA EXPANSION PROGRAM

Section 2560. Community doula expansion grant program.
2561. Definitions.
2562. Rules.
2563. Report.

§ 2560. Community doula expansion grant program. The community doula expansion grant program is established within the department.

§ 2561. Definitions. As used in this title:

1. "Eligible providers" shall mean community-based organizations providing for the recruitment, training, certification, supporting, and/or mentoring of community-based doulas.

2. "Community-based doula" shall mean a certified doula that provides culturally sensitive pregnancy and childbirth education, early linkage to health care, and aids birthing persons in navigating other services and supports that they may need to be healthy.

§ 2562. Rules. 1. The commissioner shall establish a community doula expansion grant program for eligible providers to receive funding in the performance of recruitment, training, certification, supporting, and/or mentoring of community-based doulas. Such eligible providers shall meet professionally recognized training standards, comply with applicable state law and regulations, and shall be capable of providing culturally congruent care.

2. The commissioner is authorized, within amounts appropriated for such purpose, to make grants in accordance with this subdivision. Such grants may be used for but not limited to the administration, faculty recruitment and development, start-up costs and other costs incurred for providing recruitment, training, certification, supporting, and/or mentoring of community-based doulas.

3. There shall be an emphasis of appropriating grants to eligible providers that specifically train, recruit, and employ doulas from historically vulnerable communities, and bilingual doulas. This may include grants for doula apprentice programs.

4. Information about the community doula expansion grant program shall be posted on the department's website.

§ 2563. Report. Upon expiration of the program, the commissioner shall post a final report on the department's website outlining the total number of grants awarded, the names of eligible providers awarded funds pursuant to the program, and the amount of funding received by each.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that the provisions of section two of this act shall expire March 31, 2025 when upon such date the provisions of such section shall be deemed repealed.

PART LL

Section 1. Paragraph (g) of subdivision 2 of section 2807 of the public health law is amended by adding a new subparagraph (iii) to read as follows:

(iii) (A) For purposes of this subparagraph:

(1) "Children with medical fragility" shall mean an individual who is under twenty-one years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and who meets one or more of the following criteria: (I) is technology-dependent for life or health sustaining functions; (II) requires complex medication regimens or medical interventions to maintain or to improve their health status; or (III) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.

(2) "Pediatric residential health care facility" shall mean a free-standing facility or discrete unit within a facility authorized by the commissioner to provide extensive nursing, medical, psychological, and counseling support services solely to children under the age of twenty-one.

(3) "Pediatric diagnostic and treatment center" shall mean a diagnostic and treatment center established pursuant to this article, which as of April first, two thousand twenty-four, has been participating in the demonstration program authorized under subdivision one of section twenty-eight hundred eight-e of this article, for which at least eighty percent of its total Medicaid fee-for-service reimbursements derive from the provision of services to children under the age of twenty-one with medical fragility and is affiliated with a pediatric residential health care facility.

(B) (1) Notwithstanding any law, rule, or regulation to the contrary, the commissioner shall establish rates of reimbursement for pediatric diagnostic and treatment centers for all services provided on or after

April first, two thousand twenty-four, to children eligible for medical assistance that reflect the costs necessary to provide care and services to children with medical fragility being treated at such pediatric diagnostic and treatment center.

(2) For the period April first, two thousand twenty-four, to December thirty-first, two thousand twenty-four, and until such time as a certified annual cost report for such period is received and verified by the department, the operating component of such rate shall reflect budgeted costs for the period January first, two thousand twenty-four, through December thirty-first, two thousand twenty-four, as submitted to the department and adjusted as the commissioner deems appropriate. Upon submission and subsequent verification of the cost report, the operating component of the rate shall be reflective of actual costs for the period January first, two thousand twenty-four, through December thirty-first, two thousand twenty-four, subject to further adjustments as the commissioner deems appropriate. Thereafter, the base period reported operating costs used to establish rates pursuant to this subparagraph shall be updated no less frequently than every two years. In addition to required annual cost reports, pediatric diagnostic and treatment centers, as defined by this subparagraph, shall submit additional data as the commissioner requires.

(3) Notwithstanding any law, rule, or regulation to the contrary, pediatric diagnostic and treatment centers shall be reimbursed for services provided to children enrolled in Medicaid managed care plans at the rates of reimbursement promulgated pursuant to this subparagraph.

(4) The capital component of the rate shall reflect actual base year costs.

(5) All rates established under this subparagraph shall be subject to the availability of federal financial participation.

(6) The commissioner may promulgate or amend regulations as the commissioner determines appropriate and necessary to establish the rates provided for in this subparagraph and/or exempt pediatric diagnostic and treatment centers from the ambulatory payment group reimbursement methodology applicable to diagnostic and treatment centers.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that the provisions of this act shall expire and be deemed repealed April 1, 2027.

PART MM

Section 1. The executive law is amended by adding a new article 49-C to read as follows:

ARTICLE 49-C

COMMUNITY ADVISORY BOARD FOR THE MODERNIZATION AND REVITALIZATION OF SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY

§ 996. Community advisory board for the modernization and revitalization of SUNY Downstate health sciences university.

§ 996. Community advisory board for the modernization and revitalization of SUNY Downstate health sciences university. 1. Advisory board established. (a) There shall be established the advisory board for the modernization and revitalization of SUNY Downstate (hereinafter referred to as "the advisory board"). The advisory board shall review and examine a variety of options to strengthen SUNY Downstate and promote longer term viability for its dual education and healthcare mission. In

conducting its study, the advisory board will consider the following factors:

(i) Overall healthcare service delivery trends and models;

(ii) Historic and projected financials for the hospital and the campus;

(iii) Current state of building infrastructure and capital needs;

(iv) Community healthcare needs, outcomes, and health disparities;

(v) Existing inpatient and outpatient service offerings and health outcomes;

(vi) Capacity and availability of inpatient and outpatient services in the broader primary and secondary service areas;

(vii) Efficiency of operations and quality of healthcare services benchmarking; and

(viii) Training needs for students and employment outcomes.

2. Advisory board members. The advisory board shall consist of the following members: (a) the commissioner of the department of health; (b) one representative of organized labor representing employees at the state university of New York pursuant to article fourteen of the civil service law, who shall be appointed by the governor upon recommendation of the president of the union representing the greatest number of employees at SUNY Downstate; (c) one member appointed by the temporary president of the senate; (d) one member appointed by the speaker of the assembly; (e) three members appointed by the governor; (f) one member appointed by the governor upon the joint recommendation of Brooklyn community boards 9 and 17; and (g) the chancellor of the state university of New York.

3. Outreach. The advisory board shall solicit recommendations from healthcare experts, county health departments, community-based organizations, state and regional healthcare industry associations, labor unions, experts in hospital operations, and other interested parties. The advisory board shall hold no less than three public hearings with requisite public notice to solicit input and recommendations from any interested party.

4. Compensation. The members of the advisory board shall receive no compensation for their service as members, but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

5. Recommendations and report. (a) The advisory board shall complete a study and provide written recommendations to prioritize healthcare services provided in the SUNY Downstate service area. The written recommendations shall include a reasonable, scalable and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate; provided, however, that such plan shall incorporate utilization of all available state and federally available appropriated amounts, and shall not exceed more than two hundred fifty percent of such amounts.

(b) A report of the advisory board's recommendations shall be provided to the governor, the temporary president of the senate, and the speaker of the assembly no later than April first, two thousand twenty-five.

6. Certificate of need. The public health and health planning council and the commissioner of health are prohibited from reviewing or approving any certificate of need application related to a reduction in inpatient services pursuant to any article of law or regulation that may affect a change to inpatient services at SUNY Downstate health sciences university until at least April first, two thousand twenty-five.

§ 2. This act shall take effect immediately.

PART NN

Section 1. Section 1-a of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, as added by section 8 of part E of chapter 57 of the laws of 2023, is amended to read as follows:

§ 1-a. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of hospital inpatient services shall be subject to a uniform rate increase of seven and one-half percent in addition to the increase contained in section one of this act, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of hospital outpatient services shall be subject to a uniform rate increase of six and one-half percent in addition to the increase contained in section one of this act, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the period April 1, 2024 through March 31, 2025 Medicaid payments made for hospital services shall be increased by an aggregate amount of up to $525,000,000 in addition to the increase contained in sections one and one-b of this act subject to the approval of the commissioner of health and the director of the budget. Such rate [increase] increases shall be subject to federal financial participation.

§ 2. Section 1-a of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, as added by section 7 of part I of chapter 57 of the laws of 2023, is amended to read as follows:

§ [1-a] 1-b. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of residential health care facilities services shall be subject to a uniform rate increase of 6.5 percent in addition to the increase contained in subdivision 1 of section 1 of this part, subject to the approval of the commissioner of the department of health and the director of the division of the budget; provided, however, that such Medicaid payments shall be subject to a uniform rate increase of up to 7.5 percent in addition to the increase contained in subdivision 1 of section 1 of this part contingent upon approval of the commissioner of the department of health, the director of the division of the budget, and the Centers for Medicare and Medicaid Services. Notwithstanding any provision of law to the contrary, for the period April 1, 2024 through March 31, 2025 Medicaid payments made for nursing home services shall be increased by an aggregate amount of up to $285,000,000 in addition to the increase contained in sections one and one-c of this act subject to the approval of the commissioner of health and the director of the budget. Such rate [increase] increases shall be subject to federal financial participation.

§ 3. Section 1-b of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, as added by section 7 of part I of chapter 57 of the laws of 2023, is amended to read as follows:

§ [1-b] 1-c. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of assisted living programs as

defined by paragraph (a) of subdivision one of section 461-l of the social services law shall be subject to a uniform rate increase of 6.5 percent in addition to the increase contained in section one of this part, subject to the approval of the commissioner of the department of health and the director of division of the budget. Notwithstanding any provision of law to the contrary, for the period April 1, 2024 through March 31, 2025, Medicaid payments for assisted living programs shall be increased by up to $15,000,000 in addition to the increase contained in this section subject to the approval of the commissioner of health and the director of the budget. Such rate [increase] increases shall be subject to federal financial participation.

§ 4. Part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, is amended by adding a new section 1-d to read as follows:

§ 1-d. Such increases as added by the chapter of the laws of 2024 that added this section may take the form of increased rates of payment in Medicaid fee-for-service and/or Medicaid managed care, lump sum payments, or state directed payments under 42 CFR 438.6(c). Such rate increases shall be subject to federal financial participation.

§ 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

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