STATE OF NEW YORK

S. 8007 A. 9007

SENATE - ASSEMBLY

January 19, 2022

IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

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

AN ACT to amend the public health law, in relation to the implementation of the Nurses Across New York (NANY) program (Part A); to amend the education law, in relation to enacting the interstate medical licensure compact; and to amend the education law, in relation to enacting the nurse licensure compact (Part B); to amend the public health law and the education law, in relation to allowing pharmacists to direct limited service laboratories and order waived tests and modernizing nurse practitioners and, in relation to regulations for medication-related tasks provided by certified medical aides; to amend the education law, in relation to allowing for certain individuals to administer tests to determine the presence of SARS-CoV-2 or its antibodies, influenza virus or respiratory syncytial virus in certain situations; to amend part D of chapter 56 of the laws of 2014, amending the education law relating to enacting the "nurse practitioners modernization act", in relation to the effectiveness thereof; and providing for the repeal of certain provisions upon the expiration thereof (Part C); to amend the social services law, in relation to establishing the health care and mental hygiene worker bonuses (Part D); to amend the public health law, in relation to increasing general public health work base grants for both full-service and partial-service counties and allow for local health departments to claim up to fifty percent of personnel service costs (Part E); to amend the public health law, in relation to the modernization of the emergency medical system (Part F); to repeal articles governing healthcare professions in the education law and adding such laws to the public health law and transferring all functions, powers, duties and obligations relating thereto (Part G); to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund Medicaid expenditures, in relation to the cap on local Medicaid expenditures (Part H); relating to provide a one

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

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percent across the board payment increase to all qualifying fee-for-service Medicaid rates (Part I); to amend the public health law, in relation to extending the statutory requirement to reweight and rebase acute hospital rates (Part J); to amend the public health law, in relation to the creation of a new statewide health care facility transformation program (Part K); to amend the public health law, in relation to streamlining and adding criteria to the certificate of need process (Part L); to amend the public health law, in relation to the definition of revenue in the minimum spending statute for nursing homes and the rates of payment and rates of reimbursement for residential health care facilities, and in relation to making a temporary payment to facilities in severe financial distress (Part M); to amend the social services law, in relation to Medicaid eligibility requirements for seniors and disabled individuals; and to repeal certain provisions of such law relating thereto (Part N); to amend the social services law, in relation to private duty nursing services reimbursement for nurses servicing adult members; to amend part MM of chapter 56 of the laws of 2020 directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, in relation to directing the department of health to develop guidelines and standards for the use of tasking tools; and to amend the public health law, in relation to establishing programs of all-inclusive care for the elderly (Part O); to amend the social services law and the public health law, in relation to providing authority for the department of health to competitively procure managed care organizations and requiring Medicaid managed care organizations, the essential plan and qualified health plans to contract with national cancer institute-designated cancer centers, where such centers agree to certain terms and conditions; and to repeal certain provisions of the social services law relating thereto (Part P); to amend the public health law and the social services law, in relation 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; to amend the social services law, in relation to allowing pregnant individuals to be eligible for the basic health program and maintain coverage in the basic health program for one year post pregnancy and to deem a child born to an individual covered under the basic health program to be eligible for medical assistance; and providing for the repeal of certain provisions upon the expiration thereof (Part Q); to amend the insurance law, in relation to requiring private insurance plans to cover abortion services without cost-sharing (Part R); to amend the social services law, in relation to including expanded pre-natal and post-partum care as standard coverage when determined to be necessary and the continuance of eligibility for pregnant individuals to receive medical assistance in certain situations; and to repeal section 369-hh of the social services law (Part S); to amend the public health law, in relation to requiring third trimester syphilis testing (Part T); to amend the public health law, in relation to expanding benefits in the Child Health Plus Program, eliminating the premium contribution for certain households and transferring Child Health Plus rate setting authority from the Department of Financial Services to the Department of Health (Part U); to amend the public health law and the insurance law, in relation to reimbursement for commercial and Medicaid services provided via telehealth

(Part V); to amend the social services law, in relation to eliminating unnecessary requirements from the utilization threshold program (Part W); to amend the public health law, in relation to redefining the duties and renaming the office of minority health to the office of health equity and renaming the minority health council to the health equity council (Part X); to amend the domestic relations law, in relation to marriage certificates (Part Y); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to the purchase of excess coverage by physicians and dentists and reimbursement of costs therefor, and to extending the physicians medical malpractice program; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part Z); to amend the financial services law, the insurance law and the public health law, in relation to clarifying provisions regarding emergency medical services and surprise bills; and to repeal certain provisions of such law relating thereto (Subpart A); to amend the insurance law and the public health law, in relation to the federal no surprises act (Subpart B); and to amend the insurance law and the public health law, in relation to administrative simplification (Subpart C) (Part AA); to amend the public health law, in relation to prescriber prevails; and to repeal certain provisions of the social services law relating to coverage for certain prescription drugs (Part BB); to amend the social services law, the executive law and the public health law, in relation to extending various provisions relating to health and mental hygiene; to amend chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness thereof; to amend chapter 54 of the laws of 2016, amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, in relation to the effectiveness thereof; to amend chapter 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 chapter 74 of the laws of 2020, relating to directing the department of health to convene a work group on rare diseases, in relation to the effectiveness thereof; and to amend chapter 414 of the laws of 2018, creating the radon task force, in relation to the effectiveness thereof (Part CC); in relation to establishing a cost of

living adjustment for designated human services programs (Part DD); to amend the mental hygiene law, in relation to a 9-8-8 suicide prevention and behavioral health crisis hotline system (Part EE); to amend the social services law, in relation to reinvesting savings recouped from behavioral health transition into managed care back into behavioral health services (Part FF); to amend chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof (Part GG); to amend the public health law, in relation to requiring a stock of opioid agonist medication for the treatment of an opioid use disorder (Part HH); to amend the mental hygiene law, in relation to community residences for addiction (Part II); to amend the mental hygiene law, in relation to expanding the scope of the alcohol awareness program to become the substance use awareness program (Part JJ); to amend the facilities development corporation act in relation to authorizing the facilities development corporation to acquire, improve and lease mental health facilities providing services for the treatment of addiction (Part KK); to amend chapter 56 of the laws of 2013 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and referencing the office of addiction services and supports; to amend part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services referencing the office of addiction services and supports and in relation to the effectiveness thereof (Part LL); to amend Kendra's law, in relation to extending the expiration thereof; and to amend the mental hygiene law, in relation to extending Kendra's law and assisted outpatient treatment (Part MM); to amend the mental hygiene law, in relation to rental and mortgage payments for the mentally ill (Part NN); and to amend part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, in relation to the effectiveness thereof (Part OO)

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

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

PART A

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

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

§ 2807-aa. Nurse loan repayment program. 1.(a) Monies shall be made available, subject to appropriations, for purposes of loan repayment in accordance with the provisions of this section for registered professional nurses licensed to practice pursuant to section sixty-nine hundred five of the education law. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and sections one hundred forty-two and one hundred forty-three of the economic development law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposals.

(i) Funding awarded pursuant to this section shall be awarded to repay loans of nurses who work in areas determined to be underserved communities by the commissioner and who agree to work in such areas for a period of three consecutive years. A nurse may be deemed to be practicing in an underserved area if they practice in a facility or physician's office that primarily serves an underserved population as determined by the commissioner, without regard to whether the population or the facility or physician's office is located in an underserved area.

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

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

(iv) In the event that a three-year commitment pursuant to the agreement referenced in subparagraph (i) of this paragraph is not fulfilled, the recipient shall be responsible for repayment of amounts paid which shall be calculated in accordance with the formula set forth in subdivision (b) of section two hundred fifty-four-o of title forty-two of the United States Code, as amended.

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

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

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

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

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

PART B

Section 1. The education law is amended by adding a new article 169 to read as follows:

ARTICLE 169

INTERSTATE MEDICAL LICENSURE COMPACT

§ 8860. Short title. This article shall be known and may be cited as the "interstate medical licensure compact".

§ 8861. Purpose. In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the interstate medical licensure compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing medical practice act. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the compact.

§ 8862. Definitions. In this compact:

1. "Bylaws" means those bylaws established by the interstate commission pursuant to section eighty-eight hundred seventy-one of this article for its governance, or for directing and controlling its actions and conduct.

2. "Commissioner" means the voting representative appointed by each member board pursuant to section eighty-eight hundred seventy-one of this article.

3. "Conviction" means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

4. "Expedited license" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.

5. "Interstate commission" means the interstate commission created pursuant to section eighty-eight hundred seventy-one of this article.

6. "License" means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

7. "Medical practice act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

8. "Member board" means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

9. "Member state" means a state that has enacted the compact.

10. "Practice of medicine" means the clinical prevention, diagnosis, or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the medical practice act of a member state.

11. "Physician" means any person who:

(a) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(b) Passed each component of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(c) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(d) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(e) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(f) Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(g) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or

foreign jurisdiction, excluding any action related to non-payment of fees related to a license;

(h) Has never had a controlled substance license or permit suspended or revoked by a state or the United States drug enforcement administration; and

(i) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

12. "Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

13. "Rule" means a written statement by the interstate commission promulgated pursuant to section eighty-eight hundred seventy-two of this article that is of general applicability, implements, interprets, or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the interstate commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal, or suspension of an existing rule.

14. "State" means any state, commonwealth, district, or territory of the United States.

15. "State of principal license" means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.

§ 8863. Eligibility. 1. A physician must meet the eligibility requirements as defined in subdivision eleven of section eighty-eight hundred sixty-two of this article to receive an expedited license under the terms and provisions of the compact.

2. A physician who does not meet the requirements of subdivision eleven of section eighty-eight hundred sixty-two of this article may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the compact, relating to the issuance of a license to practice medicine in that state.

§ 8864. Designation of state of principal license. 1. A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(a) the state of primary residence for the physician, or

(b) the state where at least twenty-five percent of the practice of medicine occurs, or

(c) the location of the physician's employer, or

(d) if no state qualifies under paragraph (a), (b), or (c) of this subdivision, the state designated as state of residence for purpose of federal income tax.

2. A physician may redesignate a member state as state of principal license at any time, as long as the state meets the requirements of subdivision one of this section.

3. The interstate commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

§ 8865. Application and issuance of expedited licensure. 1. A physician seeking licensure through the compact shall file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

2. Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and

issue a letter of qualification, verifying or denying the physician's eligibility, to the interstate commission.

(a) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the interstate commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal license.

(b) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with U.S. C.F.R. § 731.202.

(c) Appeal on the determination of eligibility shall be made to the member state where the application was filed and shall be subject to the law of that state.

3. Upon verification under subdivision two of this section, physicians eligible for an expedited license shall complete the registration process established by the interstate commission to receive a license in a member state selected pursuant to subdivision one of this section, including the payment of any applicable fees.

4. After receiving verification of eligibility under subdivision two of this section and any fees under subdivision three of this section, a member board shall issue an expedited license to the physician. This license shall authorize the physician to practice medicine in the issuing state consistent with the medical practice act and all applicable laws and regulations of the issuing member board and member state.

5. An expedited license shall be valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license within the member state.

6. An expedited license obtained though the compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without redesignation of a new state of principal licensure.

7. The interstate commission is authorized to develop rules regarding the application process, including payment of any applicable fees, and the issuance of an expedited license.

§ 8866. Fees for expedited licensure. 1. A member state issuing an expedited license authorizing the practice of medicine in that state may impose a fee for a license issued or renewed through the compact.

2. The interstate commission is authorized to develop rules regarding fees for expedited licenses.

§ 8867. Renewal and continued participation. 1. A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the interstate commission if the physician:

(a) Maintains a full and unrestricted license in a state of principal license;

(b) Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(c) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign

jurisdiction, excluding any action related to non-payment of fees related to a license; and

(d) Has not had a controlled substance license or permit suspended or revoked by a state or the United States drug enforcement administration.

2. Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

3. The interstate commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

4. Upon receipt of any renewal fees collected in subdivision three of this section, a member board shall renew the physician's license.

5. Physician information collected by the interstate commission during the renewal process will be distributed to all member boards.

6. The interstate commission is authorized to develop rules to address renewal of licenses obtained through the compact.

§ 8868. Coordinated information system. 1. The interstate commission shall establish a database of all physicians licensed, or who have applied for licensure, under section eighty-eight hundred sixty-five of this article.

2. Notwithstanding any other provision of law, member boards shall report to the interstate commission any public action or complaints against a licensed physician who has applied or received an expedited license through the compact.

3. Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the interstate commission.

4. Member boards may report any non-public complaint, disciplinary, or investigatory information not required by subdivision three of this section to the interstate commission.

5. Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

6. All information provided to the interstate commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

7. The interstate commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

§ 8869. Joint investigations. 1. Licensure and disciplinary records of physicians are deemed investigative.

2. In addition to the authority granted to a member board by its respective medical practice act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

3. A subpoena issued by a member state shall be enforceable in other member states.

4. Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

5. Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

§ 8870. Disciplinary actions. 1. Any disciplinary action taken by any member board against a physician licensed through the compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the medical practice act or regulations in that state.

2. If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the medical practice act of that state.

3. If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(a) impose the same or lesser sanction or sanctions against the physician so long as such sanctions are consistent with the medical practice act of that state; or

(b) pursue separate disciplinary action against the physician under its respective medical practice act, regardless of the action taken in other member states.

4. If a license granted to a physician by a member board is revoked, surrendered, or relinquished in lieu of discipline, or suspended, then any license or licenses issued to the physician by any other member board or boards shall be suspended, automatically and immediately without further action necessary by the other member board or boards, for ninety days upon entry of the order by the disciplining board, to permit the member board or boards to investigate the basis for the action under the medical practice act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety day suspension period in a manner consistent with the medical practice act of that state.

§ 8871. Interstate medical licensure compact commission. 1. The member states hereby create the "interstate medical licensure compact commission".

2. The purpose of the interstate commission is the administration of the interstate medical licensure compact, which is a discretionary state function.

3. The interstate commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the compact.

4. The interstate commission shall consist of two voting representatives appointed by each member state who shall serve as commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall appoint one representative from each member board. A commissioner shall be a or an:

(a) Allopathic or osteopathic physician appointed to a member board;

(b) Executive director, executive secretary, or similar executive of a member board; or

(c) Member of the public appointed to a member board.

5. The interstate commission shall meet at least once each calendar year. A portion of this meeting shall be a business meeting to address such matters as may properly come before the commission, including the

election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

6. The bylaws may provide for meetings of the interstate commission to be conducted by telecommunication or electronic communication.

7. Each commissioner participating at a meeting of the interstate commission is entitled to one vote. A majority of commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the interstate commission. A commissioner shall not delegate a vote to another commissioner. In the absence of its commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who shall meet the requirements of subdivision four of this section.

8. The interstate commission shall provide public notice of all meetings and all meetings shall be open to the public. The interstate commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the commissioners present that an open meeting would be likely to:

(a) Relate solely to the internal personnel practices and procedures of the interstate commission;

(b) Discuss matters specifically exempted from disclosure by federal statute;

(c) Discuss trade secrets, commercial, or financial information that is privileged or confidential;

(d) Involve accusing a person of a crime, or formally censuring a person;

(e) Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(f) Discuss investigative records compiled for law enforcement purposes; or

(g) Specifically relate to the participation in a civil action or other legal proceeding.

9. The interstate commission shall keep minutes which shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes.

10. The interstate commission shall make its information and official records, to the extent not otherwise designated in the compact or by its rules, available to the public for inspection.

11. The interstate commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the interstate commission, with the exception of rulemaking, during periods when the interstate commission is not in session. When acting on behalf of the interstate commission, the executive committee shall oversee the administration of the compact including enforcement and compliance with the provisions of the compact, its bylaws and rules, and other such duties as necessary.

12. The interstate commission may establish other committees for governance and administration of the compact.

§ 8872. Powers and duties of the interstate commission. The interstate commission shall have the duty and power to:

1. Oversee and maintain the administration of the compact;

2. Promulgate rules which shall be binding to the extent and in the manner provided for in the compact;

3. Issue, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the compact, its bylaws, rules, and actions;

4. Enforce compliance with compact provisions, the rules promulgated by the interstate commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

5. Establish and appoint committees including, but not limited to, an executive committee as required by section eighty-eight hundred seventy-one of this article, which shall have the power to act on behalf of the interstate commission in carrying out its powers and duties;

6. Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the interstate commission;

7. Establish and maintain one or more offices;

8. Borrow, accept, hire, or contract for services of personnel;

9. Purchase and maintain insurance and bonds;

10. Employ an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their duties, and fix their compensation;

11. Establish personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel;

12. Accept donations and grants of money, equipment, supplies, materials and services, and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the interstate commission;

13. Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed;

14. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

15. Establish a budget and make expenditures;

16. Adopt a seal and bylaws governing the management and operation of the interstate commission;

17. Report annually to the legislatures and governors of the member states concerning the activities of the interstate commission during the preceding year. Such reports shall also include reports of financial audits and any recommendations that may have been adopted by the interstate commission;

18. Coordinate education, training, and public awareness regarding the compact, its implementation, and its operation;

19. Maintain records in accordance with the bylaws;

20. Seek and obtain trademarks, copyrights, and patents; and

21. Perform such functions as may be necessary or appropriate to achieve the purposes of the compact.

§ 8873. Finance powers. 1. The interstate commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the interstate commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the interstate commission, which shall promulgate a rule binding upon all member states.

2. The interstate commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

3. The interstate commission shall not pledge the credit of any of the member states, except by, and with the authority of, the member state.

4. The interstate commission shall be subject to a yearly financial audit conducted by a certified or licensed public accountant and the report of the audit shall be included in the annual report of the interstate commission.

§ 8874. Organization and operation of the interstate commission. 1. The interstate commission shall, by a majority of commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact within twelve months of the first interstate commission meeting.

2. The interstate commission shall elect or appoint annually from among its commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the interstate commission.

3. Officers selected pursuant to subdivision two of this section shall serve without remuneration from the interstate commission.

4. The officers and employees of the interstate commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of interstate commission employment, duties, or responsibilities; provided that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(a) The liability of the executive director and employees of the interstate commission or representatives of the interstate commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The interstate commission is considered to be an instrumentality of the states for the purposes of any such action. Nothing in this paragraph shall be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(b) The interstate commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an interstate commission representative, shall defend such interstate commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of interstate commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of interstate commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(c) To the extent not covered by the state involved, member state, or the interstate commission, the representatives or employees of the interstate commission shall be held harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of interstate commission employment,

duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of interstate commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

§ 8875. Rulemaking functions of the interstate commission. 1. The interstate commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the compact. Notwithstanding the foregoing, in the event the interstate commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the compact, or the powers granted hereunder, then such an action by the interstate commission shall be invalid and have no force or effect.

2. Rules deemed appropriate for the operations of the interstate commission shall be made pursuant to a rulemaking process that substantially conforms to the federal Model State Administrative Procedure Act of 2010, and subsequent amendments thereto.

3. Not later than thirty days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the interstate commission has its principal offices, provided that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the interstate commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the interstate commission.

§ 8876. Oversight of interstate compact. 1. The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and shall take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of the compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

2. All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities or actions of the interstate commission.

3. The interstate commission shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the interstate commission shall render a judgment or order void as to the interstate commission, the compact, or promulgated rules.

§ 8877. Enforcement of interstate compact. 1. The interstate commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

2. The interstate commission may, by majority vote of the commissioners, initiate legal action in the United States District Court for the District of Columbia, or, at the discretion of the interstate commission, in the federal district where the interstate commission has its principal offices, to enforce compliance with the provisions of the compact, and its promulgated rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing

party shall be awarded all costs of such litigation including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the interstate commission. The interstate commission may avail itself of any other remedies available under state law or the regulation of a profession.

§ 8878. Default procedures. 1. The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the compact, or the rules and bylaws of the interstate commission promulgated under the compact.

2. If the interstate commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, or the bylaws or promulgated rules, the interstate commission shall:

(a) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the interstate commission. The interstate commission shall specify the conditions by which the defaulting state must cure its default; and

(b) Provide remedial training and specific technical assistance regarding the default.

3. If the defaulting state fails to cure the default, the defaulting state shall be terminated from the compact upon an affirmative vote of a majority of the commissioners and all rights, privileges, and benefits conferred by the compact shall terminate on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

4. Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate shall be given by the interstate commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

5. The interstate commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

6. The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination including obligations, the performance of which extends beyond the effective date of termination.

7. The interstate commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the compact, unless otherwise mutually agreed upon in writing between the interstate commission and the defaulting state.

8. The defaulting state may appeal the action of the interstate commission by petitioning the United States District Court for the District of Columbia or the federal district where the interstate commission has its principal offices. The prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

§ 8879. Dispute resolution. 1. The interstate commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the compact and which may arise among member states or member boards.

2. The interstate commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

§ 8880. Member states, effective date and amendment. 1. Any state is eligible to become a member state of the compact.

2. The compact shall become effective and binding upon legislative enactment of the compact into law by no less than seven states. Thereafter, it shall become effective and binding on a state upon enactment of the compact into law by that state.

3. The governors of non-member states, or their designees, shall be invited to participate in the activities of the interstate commission on a non-voting basis prior to adoption of the compact by all states.

4. The interstate commission may propose amendments to the compact for enactment by the member states. No amendment shall become effective and binding upon the interstate commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

§ 8881. Withdrawal. 1. Once effective, the compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the compact by specifically repealing the statute which enacted the compact into law.

2. Withdrawal from the compact shall be by the enactment of a statute repealing the same, but shall not take effect until one year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

3. The withdrawing state shall immediately notify the chairperson of the interstate commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

4. The interstate commission shall notify the other member states of the withdrawing state's intent to withdraw within sixty days of its receipt of notice provided under subdivision three of this section.

5. The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

6. Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or upon such later date as determined by the interstate commission.

7. The interstate commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

§ 8882. Dissolution. 1. The compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the compact to one member state.

2. Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the interstate commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

§ 8883. Severability and construction. 1. The provisions of the compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

2. The provisions of the compact shall be liberally construed to effectuate its purposes.

3. Nothing in the compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

§ 8884. Binding effect of compact and other laws. 1. Nothing contained in this article shall prevent the enforcement of any other law of a member state that is not inconsistent with the compact.

2. All laws in a member state in conflict with the compact are superseded to the extent of the conflict.

3. All lawful actions of the interstate commission, including all rules and bylaws promulgated by the commission, are binding upon the member states.

4. All agreements between the interstate commission and the member states are binding in accordance with their terms.

5. In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

§ 2. Article 170 of the education law is renumbered article 171 and a new article 170 is added to title 8 of the education law to read as follows:

ARTICLE 170
NURSE LICENSURE COMPACT

Section 8900. Nurse licensure compact.
8901. Findings and declaration of purpose.
8902. Definitions.
8903. General provisions and jurisdiction.
8904. Applications for licensure in a party state.
8905. Additional authorities invested in party state licensing boards.
8906. Coordinated licensure information system and exchange of information.
8907. Establishment of the interstate commission of nurse licensure compact administrators.
8908. Rulemaking.
8909. Oversight, dispute resolution and enforcement.
8910. Effective date, withdrawal and amendment.
8911. Construction and severability.

§ 8900. Nurse licensure compact. The nurse license compact as set forth in the article is hereby adopted and entered into with all party states joining therein.

§ 8901. Findings and declaration of purpose 1. Findings. The party states find that:

a. The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;

b. Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;

c. The expanded mobility of nurses and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;

d. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;

e. The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states; and

f. Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

2. Declaration of purpose. The general purposes of this compact are to:

a. Facilitate the states' responsibility to protect the public's health and safety;

b. Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;

c. Facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;

d. Promote compliance with the laws governing the practice of nursing in each jurisdiction;

e. Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses;

f. Decrease redundancies in the consideration and issuance of nurse licenses; and

g. Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

§ 8902. Definitions. 1. Definitions. As used in this compact:

a. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

b. "Alternative program" means a non-disciplinary monitoring program approved by a licensing board.

c. "Coordinated licensure information system" means an integrated process for collecting, storing and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

d. "Commission" means the interstate commission of nurse licensure compact administrators.

e. "Current significant investigative information" means:

1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

2. Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond; or

3. Any information concerning a nurse reported to a licensing board by a health care entity, health care professional, or any other person, which indicates that the nurse demonstrated an impairment, gross incompetence, or unprofessional conduct that would present an imminent danger to a patient or the public health, safety, or welfare.

f. "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

g. "Home state" means the party state which is the nurse's primary state of residence.

h. "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

i. "Multistate license" means a license to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), which is issued by a home state licensing board, and which authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

j. "Multistate licensure privilege" means a legal authorization associated with a multistate license permitting the practice of nursing as either a RN or a LPN/VN in a remote state.

k. "Nurse" means RN or LPN/VN, as those terms are defined by each party state's practice laws.

l. "Party state" means any state that has adopted this compact.

m. "Remote state" means a party state, other than the home state.

n. "Single-state license" means a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

o. "State" means a state, territory or possession of the United States and the District of Columbia.

p. "State practice laws" means a party state's laws, rules and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. "State practice laws" shall not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

§ 8903. General provisions and jurisdiction. 1. General provisions and jurisdiction. a. A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), under a multistate licensure privilege, in each party state.

b. A state shall implement procedures for considering the criminal history records of applicants for an initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the federal bureau of investigation and the agency responsible for retaining that state's criminal records.

c. Each party state shall require its licensing board to authorize an applicant to obtain or retain a multistate license in the home state only if the applicant:

i. Meets the home state's qualifications for licensure or renewal of licensure, and complies with all other applicable state laws;

ii. (1) Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program; or

(2) Has graduated from a foreign RN or LPN/VN prelicensure education program that has been: (A) approved by the authorized accrediting body in the applicable country, and (B) verified by an independent credentials review agency to be comparable to a licensing board-approved prelicensure education program;

iii. Has, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing and listening;

iv. Has successfully passed an NCLEX-RN or NCLEX-PN examination or recognized predecessor, as applicable;

v. Is eligible for or holds an active, unencumbered license;

vi. Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the federal bureau of investigation and the agency responsible for retaining that state's criminal records;

vii. Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;

viii. Has not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;

ix. Is not currently enrolled in an alternative program;

x. Is subject to self-disclosure requirements regarding current participation in an alternative program; and

xi. Has a valid United States social security number.

d. All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

e. A nurse practicing in a party state shall comply with the state practice laws of the state in which the client is located at the time service is provided. The practice of nursing is not limited to patient care but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts and the laws of the party state in which the client is located at the time service is provided.

f. Individuals not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this compact shall affect the requirements established by a party state for the issuance of a single-state license.

g. Any nurse holding a home state multistate license, on the effective date of this compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:

i. A nurse, who changes primary state of residence after this compact's effective date, shall meet all applicable requirements set forth in this article to obtain a multistate license from a new home state.

ii. A nurse who fails to satisfy the multistate licensure requirements set forth in this article due to a disqualifying event occurring after this compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the commission.

§ 8904. Applications for licensure in a party state. 1. Applications for licensure in a party state. a. Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.

b. A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

c. If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the commission.

i. The nurse may apply for licensure in advance of a change in primary state of residence.

ii. A multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.

d. If a nurse changes primary state of residence by moving from a party state to a non-party state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

§ 8905. Additional authorities invested in party state licensing boards. 1. Licensing board authority. In addition to the other powers conferred by state law, a licensing board shall have the authority to:

a. Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

i. Only the home state shall have the power to take adverse action against a nurse's license issued by the home state.

ii. For purposes of taking adverse action, the home state licensing board shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

b. Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.

c. Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action or actions and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

d. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses,

mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.

e. Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the federal bureau of investigation for criminal background checks, receive the results of the federal bureau of investigation record search on criminal background checks and use the results in making licensure decisions.

f. If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.

g. Take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.

2. Adverse actions. a. If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

b. Nothing in this compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

§ 8906. Coordinated licensure information system and exchange of information. 1. Coordinated licensure information system and exchange of information. a. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

b. The commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this compact.

c. All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications with the reasons for such denials and nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.

d. Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

e. Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

f. Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall not be shared with non-party states or disclosed to other entities

or individuals except to the extent permitted by the laws of the party state contributing the information.

g. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

h. The compact administrator of each party state shall furnish a uniform data set to the compact administrator of each other party state, which shall include, at a minimum:

i. Identifying information;

ii. Licensure data;

iii. Information related to alternative program participation; and

iv. Other information that may facilitate the administration of this compact, as determined by commission rules.

i. The compact administrator of a party state shall provide all investigative documents and information requested by another party state.

§ 8907. Establishment of the interstate commission of nurse licensure compact administrators. 1. Commission of nurse licensure compact administrators. The party states hereby create and establish a joint public entity known as the interstate commission of nurse licensure compact administrators. The commission is an instrumentality of the party states.

2. Venue. Venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Sovereign immunity. Nothing in this compact shall be construed to be a waiver of sovereign immunity.

4. Membership, voting and meetings. a. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the administrator is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

b. Each administrator shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.

c. The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the commission.

d. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in section eighty-nine hundred three of this article.

5. Closed meetings. a. The commission may convene in a closed, nonpublic meeting if the commission shall discuss:

i. Noncompliance of a party state with its obligations under this compact;

ii. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other

matters related to the commission's internal personnel practices and procedures;

iii. Current, threatened or reasonably anticipated litigation;

iv. Negotiation of contracts for the purchase or sale of goods, services or real estate;

v. Accusing any person of a crime or formally censuring any person;

vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

viii. Disclosure of investigatory records compiled for law enforcement purposes;

ix. Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with this compact; or

x. Matters specifically exempted from disclosure by federal or state statute.

b. If a meeting, or portion of a meeting, is closed pursuant to this paragraph the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

c. The commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this compact, including but not limited to:

i. Establishing the fiscal year of the commission;

ii. Providing reasonable standards and procedures:

(1) For the establishment and meetings of other committees; and

(2) Governing any general or specific delegation of any authority or function of the commission;

iii. Providing reasonable procedures for calling and conducting meetings of the commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;

iv. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the commission;

v. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the commission; and

vi. Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist

after the termination of this compact after the payment or reserving of all of its debts and obligations.

6. General provisions. a. The commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the commission.

b. The commission shall maintain its financial records in accordance with the bylaws.

c. The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

7. Powers of the commission. The commission shall have the following powers:

a. To promulgate uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and shall be binding in all party states;

b. To bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any licensing board to sue or be sued under applicable law shall not be affected;

c. To purchase and maintain insurance and bonds;

d. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;

e. To cooperate with other organizations that administer state compacts related to the regulation of nursing, including but not limited to sharing administrative or staff expenses, office space or other resources;

f. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this compact, and to establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

g. To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the commission shall avoid any appearance of impropriety or conflict of interest;

h. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, whether real, personal or mixed; provided that at all times the commission shall avoid any appearance of impropriety;

i. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, whether real, personal or mixed;

j. To establish a budget and make expenditures;

k. To borrow money;

l. To appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, and consumer representatives, and other such interested persons;

m. To provide and receive information from, and to cooperate with, law enforcement agencies;

n. To adopt and use an official seal; and

o. To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of nurse licensure and practice.

8. Financing of the commission. a. The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

b. The commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule that is binding upon all party states.

c. The commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the commission pledge the credit of any of the party states, except by, and with the authority of, such party state.

d. The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the commission.

9. Qualified immunity, defense and indemnification. a. The administrators, officers, executive director, employees and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of the commission's employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional, willful or wanton misconduct of that person.

b. The commission shall defend any administrator, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of the commission's employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of the commission's employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.

c. The commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of the commission's employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of the commission's employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

§ 8908. Rulemaking. 1. Rulemaking. a. The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this compact.

b. Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

2. Notice. a. Prior to promulgation and adoption of a final rule or rules by the commission, and at least sixty days in advance of the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

i. On the website of the commission; and

ii. On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

b. The notice of proposed rulemaking shall include:

i. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;

ii. The text of the proposed rule or amendment, and the reason for the proposed rule;

iii. A request for comments on the proposed rule from any interested person; and

iv. The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

c. Prior to adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

3. Public hearings on rules. a. The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

b. The commission shall publish the place, time and date of the scheduled public hearing.

i. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

ii. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

c. If no one appears at the public hearing, the commission may proceed with promulgation of the proposed rule.

d. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

4. Voting on rules. The commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

5. Emergency rules. Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in this compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

a. Meet an imminent threat to public health, safety or welfare;

b. Prevent a loss of the commission or party state funds; or

c. Meet a deadline for the promulgation of an administrative rule that is required by federal law or rule.

6. Revisions. The commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical

errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the commission. The revision shall be subject to challenge by any person for a period of thirty days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

§ 8909. Oversight, dispute resolution and enforcement. 1. Oversight. a. Each party state shall enforce this compact and take all actions necessary and appropriate to effectuate this compact's purposes and intent.

b. The commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities or actions of the commission, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the commission shall render a judgment or order void as to the commission, this compact or promulgated rules.

2. Default, technical assistance and termination. a. If the commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the commission shall:

i. Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default or any other action to be taken by the commission; and

ii. Provide remedial training and specific technical assistance regarding the default.

b. If a state in default fails to cure the default, the defaulting state's membership in this compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

c. Termination of membership in this compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board and each of the party states.

d. A state whose membership in this compact has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

e. The commission shall not bear any costs related to a state that is found to be in default or whose membership in this compact has been terminated unless agreed upon in writing between the commission and the defaulting state.

f. The defaulting state may appeal the action of the commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

3. Dispute resolution. a. Upon request by a party state, the commission shall attempt to resolve disputes related to the compact that arise among party states and between party and non-party states.

b. The commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.

c. In the event the commission cannot resolve disputes among party states arising under this compact:

i. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the compact administrator in each of the affected party states, and an individual mutually agreed upon by the compact administrators of all the party states involved in the dispute.

ii. The decision of a majority of the arbitrators shall be final and binding.

4. Enforcement. a. The commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

b. By majority vote, the commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

c. The remedies herein shall not be the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

§ 8910. Effective date, withdrawal and amendment. 1. Effective date. a. This compact shall become effective and binding on the earlier of the date of legislative enactment of this compact into law by no less than twenty-six states or the effective date of the chapter of the laws of two thousand twenty-two that enacted this compact. Thereafter, the compact shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state. All party states to this compact, that also were parties to the prior nurse licensure compact, superseded by this compact, (herein referred to as "prior compact"), shall be deemed to have withdrawn from said prior compact within six months after the effective date of this compact.

b. Each party state to this compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the prior compact until such party state has withdrawn from the prior compact.

2. Withdrawal. a. Any party state may withdraw from this compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six months after enactment of the repealing statute.

b. A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

c. Nothing contained in this compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this compact.

3. Amendment. a. This compact may be amended by the party states. No amendment to this compact shall become effective and binding upon the

party states unless and until it is enacted into the laws of all party states.

b. Representatives of non-party states to this compact shall be invited to participate in the activities of the commission, on a nonvoting basis, prior to the adoption of this compact by all states.

§ 8911. Construction and severability. 1. Construction and severability. This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable, and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person or circumstance is held to be invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held to be contrary to the constitution of any party state, this compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

§ 3. Section 6501 of the education law is amended by adding a new subdivision 3 to read as follows:

3. a. an applicant for licensure in a qualified high-need healthcare profession who provides documentation and attestation that he or she holds a license in good standing from another state, may request the issuance of a temporary practice permit, which, if granted will permit the applicant to work under the supervision of a New York state licensee in accordance with regulations of the commissioner. The department may grant such temporary practice permit when it appears based on the application and supporting documentation received that the applicant will meet the requirements for licensure in this state because he or she has provided documentation and attestation that they hold a license in good standing from another state with significantly comparable licensure requirements to those of this state, except the department has not been able to secure direct source verification of the applicant's underlying credentials (e.g., license verification, receipt of original transcript, experience verification). Such permit shall be valid for six months or until ten days after notification that the applicant does not meet the qualifications for licensure. An additional six months may be granted upon a determination by the department that the applicant is expected to qualify for the full license upon receipt of the remaining direct source verification documents requested by the department in such time period and that the delay in providing the necessary documentation for full licensure was due to extenuating circumstances which the applicant could not avoid.

b. a temporary practice permit issued under paragraph a of this subdivision shall be subject to the full disciplinary and regulatory authority of the board of regents and the department, pursuant to this title, as if such authorization were a professional license issued under this article.

c. for purposes of this subdivision "high-need healthcare profession" means a licensed healthcare profession of which there are an insufficient number of licensees to serve in the state or a region of the state, as determined by the commissioner of health, in consultation with the commissioner of education. The commissioner of health shall maintain a list of such licensed professions, which shall be posted online and updated from time to time as warranted.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, section three of this act shall take effect on the ninetieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART C

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

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

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

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

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

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

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

(b) Notwithstanding subparagraph (i) of paragraph (a) of this subdivision[~~,~~]**:**

(i) a nurse practitioner, certified under section sixty-nine hundred ten of this article and practicing for more than three thousand six hundred hours **in a specialty area other than primary care or such other related areas as determined by the commissioner of health,** may comply with this paragraph in lieu of complying with the requirements of paragraph (a) of this subdivision relating to collaboration with a physician, a written practice agreement and written practice protocols. A nurse practitioner complying with this paragraph shall have collaborative relationships with one or more licensed physicians qualified to collaborate in the specialty involved or a hospital, licensed under article twenty-eight of the public health law, that provides services through licensed physicians qualified to collaborate in the specialty involved and having privileges at such institution. As evidence that the nurse practitioner maintains collaborative relationships, the nurse

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

(ii) a nurse practitioner, certified under section sixty-nine hundred ten of this article and practicing for more than three thousand six hundred hours in primary care, shall be exempt from the requirements of subparagraph (i) of paragraph (a) of this subdivision. For purposes of this paragraph, "primary care" shall include but not be limited to general pediatrics, general adult medicine, general geriatric medicine, general internal medicine, obstetrics and gynecology, family medicine, or such other related areas as determined by the commissioner of health.

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

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

§ 6. Section 6908 of the education law is amended by adding a new subdivision 3 to read as follows:

3. This article shall not be construed as prohibiting medication-related tasks provided by a certified medication aide in accordance with regulations developed by the commissioner, in consultation with the commissioner of health. At a minimum, such regulations shall:

a. specify the medication-related tasks that may be performed by certified medication aides pursuant to this subdivision. Such tasks shall include the administration of medications which are routine and pre-filled or otherwise packaged in a manner that promotes relative ease of administration, provided that administration of medications by injection, sterile procedures, and central line maintenance shall be

prohibited. Provided, however, such prohibition shall not apply to injections of insulin or other injections for diabetes care, to injections of low molecular weight heparin, and to pre-filled auto-injections of naloxone and epinephrine for emergency purposes, and provided, further, that entities employing certified medication aides pursuant to this subdivision shall establish a systematic approach to address drug diversion;

b. provide that medication-related tasks performed by certified medication aides may be performed only under the supervision of a registered professional nurse licensed in New York state, as set forth in this subdivision and subdivision eleven of section sixty-nine hundred nine of this article, where such nurse is employed by a residential health care facility licensed pursuant to article twenty-eight of the public health law;

c. establish a process by which a registered professional nurse may assign medication-related tasks to a certified medication aide. Such process shall include, but not be limited to:

(i) allowing assignment of medication-related tasks to a certified medication aide only where such certified medication aide has demonstrated to the satisfaction of the supervising registered professional nurse competency in every medication-related task that such certified medication aide is authorized to perform, a willingness to perform such medication-related tasks, and the ability to effectively and efficiently communicate with the individual receiving services and understand such individual's needs;

(ii) authorizing the supervising registered professional nurse to revoke any assigned medication-related task from a certified medication aide for any reason; and

(iii) authorizing multiple registered professional nurses to jointly agree to assign medication-related tasks to a certified medication aide, provided further that only one registered professional nurse shall be required to determine if the certified medication aide has demonstrated competency in the medication-related task to be performed;

d. provide that medication-related tasks may be performed only in accordance with and pursuant to an authorized health practitioner's ordered care;

e. provide that only a certified nurse aide may perform medication-related tasks as a certified medication aide when such aide has:

(i) a valid New York state nurse aide certificate;

(ii) a high school diploma, GED or similar education credential;

(iii) evidence of being at least eighteen years old;

(iv) at least one year of experience providing nurse aide services in an article twenty-eight residential health care facility;

(v) the ability to read, write, and speak English and to perform basic math skills;

(vi) completed the requisite training and demonstrated competencies of a certified medication aide as determined by the commissioner in consultation with the commissioner of health;

(vii) successfully completed competency examinations satisfactory to the commissioner in consultation with the commissioner of health; and

(viii) meets other appropriate qualifications as determined by the commissioner in consultation with the commissioner of health;

f. prohibit a certified medication aide from holding themselves out, or accepting employment as, a person licensed to practice nursing under the provisions of this article;

g. provide that a certified medication aide is not required nor permitted to assess the medication or medical needs of an individual;

h. provide that a certified medication aide shall not be authorized to perform any medication-related tasks or activities pursuant to this subdivision that are outside the scope of practice of a licensed practical nurse or any medication-related tasks that have not been appropriately assigned by the supervising registered professional nurse;

i. provide that a certified medication aide shall document all medication-related tasks provided to an individual, including medication administration to each individual through the use of a medication administration record; and

j. provide that the supervising registered professional nurse shall retain the discretion to decide whether to assign medication-related tasks to certified medication aides under this program and shall not be subject to coercion, retaliation, or the threat of retaliation.

§ 7. Section 6909 of the education law is amended by adding a new subdivision 11 to read as follows:

11. A registered professional nurse, while working for a residential health care facility licensed pursuant to article twenty-eight of the public health law, may, in accordance with this subdivision, assign certified medication aides to perform medication-related tasks for individuals pursuant to the provisions of subdivision three of section sixty-nine hundred eight of this article and supervise certified medication aides who perform assigned medication-related tasks.

§ 8. Paragraph (a) of subdivision 3 of section 2803-j of the public health law, as added by chapter 717 of the laws of 1989, is amended to read as follows:

(a) Identification of individuals who have successfully completed a nurse aide training and competency evaluation program, [~~or~~] a nurse aide competency evaluation program, or a medication aide program;

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

(h) administering tests to determine the presence of SARS-CoV-2 or its antibodies, influenza virus or respiratory syncytial virus.

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

(h) administering tests to determine the presence of SARS-CoV-2 or its antibodies, influenza virus or respiratory syncytial virus.

§ 11. Section 6909 of the education law is amended by adding a new subdivision 11 to read as follows:

11. A registered professional nurse or certified nurse practitioner may, in accordance with this subdivision, assign the task of administering tests to determine the presence of SARS-CoV-2 or its antibodies, influenza virus or respiratory syncytial virus, to an individual, provided that:

(a) prior to making such assignment the registered professional nurse or certified nurse practitioner shall provide the individual assigned such task with specific instructions for performing the specimen collection and criteria for identifying, reporting and responding to problems or complications;

(b) the registered professional nurse or certified nurse practitioner provides training to the individual and personally verifies that the individual can safely and competently perform the tasks assigned;

(c) the registered professional nurse or certified nurse practitioner determines that the individual is willing to perform such task; and

(d) the specimen collection is consistent with an authorized health practitioner's ordered care.

§ 12. Section 6527 of the education law is amended by adding a new subdivision 11 to read as follows:

11. A physician may, in accordance with this subdivision, assign the task of administering tests to determine the presence of SARS-CoV-2 or its antibodies, influenza virus or respiratory syncytial virus, to an individual, provided that:

(a) prior to making such assignment the physician shall provide the individual assigned such task with specific instructions for performing the specimen collection and criteria for identifying, reporting and responding to problems or complications;

(b) the physician provides training to the individual and personally verifies that the individual can safely and competently perform the tasks assigned;

(c) the physician determines that the individual is willing to perform such task; and

(d) the specimen collection is consistent with an authorized health practitioner's ordered care.

§ 13. 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 six, seven and eight of this act shall expire and be deemed repealed two years after it shall have become a law.

PART D

Section 1. The social services law is amended by adding a new section 367-w to read as follows:

§ 367-w. Health care and mental hygiene worker bonuses. 1. Purpose and intent. New York's essential front line health care and mental hygiene workers have seen us through a once-in-a-century public health crisis and turned our state into a model for battling and beating COVID-19. To attract talented people into the profession at a time of such significant strain while also retaining those who have been working so tirelessly these past two years, we must recognize the efforts of our health care and mental hygiene workforce and reward them financially for their service.

To do that, the commissioner of health is hereby directed to seek additional federal spending authority under section 9817 of the American Rescue Plan Act of 2021 to maximize federal financial participation with respect to spending on home and community based services and to seek such other federal approvals as applicable, and, subject to federal financial participation, to support with federal and state funding bonuses to be made available during the state fiscal year of 2023 to recruit, retain, and reward health care and mental hygiene workers.

2. Definitions. As used in this section, the term:

(a) "Employee" means certain front line health care and mental hygiene practitioners, technicians, assistants and aides that provide hands on health or care services to individuals, without regard to whether the person works full-time, part-time, on a salaried, hourly, or temporary basis, or as an independent contractor, that received an annualized base salary of one hundred thousand dollars or less, to include such titles as determined by the commissioner, in consultation with the commissioner of mental health, the commissioner for people with developmental disabilities, the commissioner of addiction services and supports, and the

commissioner of children and family services, as applicable, and approved by the director of budget.

(b) "Employer" means a provider enrolled in the medical assistance program under this title that employs at least one employee and that bills for services under the state plan or a home and community based services waiver authorized pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act, or that has a provider agreement to bill for services provided or arranged through a managed care provider under section three hundred sixty-four-j of this title or a managed long term care plan under section forty-four hundred three-f of the public health law, to include:

(i) providers and facilities licensed, certified or otherwise authorized under articles twenty-eight, thirty, thirty-six or forty of the public health law, articles sixteen, thirty-one, thirty-two or thirty-six of the mental hygiene law, article seven of this chapter, fiscal intermediaries under section three hundred sixty-five-f of this title, and pharmacies registered under section six thousand eight hundred eight of the education law;

(ii) programs funded by the office of mental health, the office of addiction services and supports, or the office for people with developmental disabilities; and

(iii) other provider types determined by the commissioner and approved by the director of the budget;

(iv) provided, however, that unless the provider is subject to a certificate of need process as a condition of state licensure or approval, such provider shall not be an employer under this section unless at least twenty percent of the provider's patients or persons served are eligible for services under this title and title XIX of the federal social security act.

3. Tracking and submission of claims for bonuses. (a) The commissioner, in consultation with the commissioner of labor and the Medicaid inspector general, and subject to any necessary approvals by the federal centers for Medicare and Medicaid services, shall develop such forms and procedures as may be needed to identify the number of hours employees worked and to provide reimbursement to employers for the purposes of funding employee bonuses in accordance with hours worked during the vesting period.

(b) Using the forms and processes developed by the commissioner under this subdivision, employers shall, for a period of time specified by the commissioner:

(i) track the number of hours that employees work during the vesting period and, as applicable, the number of patients served by the employer who are eligible for services under this title; and

(ii) submit claims for reimbursement of employee bonus payments. In filling out the information required to submit such claims, employers shall use information obtained from tracking required pursuant to paragraph (a) of this subdivision and provide such other information as may be prescribed by the commissioner. In determining an employee's annualized base salary, the employer shall use information based on payroll records from calendar year two thousand twenty-one, if available to the employer.

(c) Employers shall be responsible for determining whether an employee is eligible under this section and shall maintain and make available upon request all records, data and information the employer relied upon in making the determination that an employee was eligible, in accordance with paragraph (d) of this subdivision.

(d) Employers shall maintain contemporaneous records for all tracking and claims related information and documents required to substantiate claims submitted under this section for a period of no less than six years. Employers shall furnish such records and information, upon request, to the commissioner, the Medicaid inspector general, the commissioner of labor, the secretary of the United States Department of Health and Human Services, and the deputy attorney general for Medicaid fraud control.

4. Payment of worker bonuses. (a) Employers shall be required to pay bonuses to employees pursuant to a schedule issued by the commissioner based on the number of hours worked during the vesting period. The schedule shall divide the payment of bonuses into two vesting periods based on the employee's start date with the employer. No employee's first vesting period may begin later than March thirty-first, two thousand twenty-three, and in total both vesting periods may not exceed one year in duration. The schedule shall provide for total payments not to exceed three thousand dollars per employee in accordance with the following:

(i) employees who have worked an average of at least twenty but less than thirty hours per week over the course of a vesting period would receive a five hundred dollar bonus for the vesting period;

(ii) employees who have worked an average of at least thirty but less than forty hours per week over the course of a vesting period would receive a one thousand dollar bonus for such vesting period;

(iii) employees who have worked an average of at least forty hours per week over the course of a vesting period would receive a one thousand five hundred dollar bonus for such vesting period.

(b) Notwithstanding paragraph (a) of this subdivision, the commissioner may through regulation specify an alternative number of vesting periods, provided that total payments do not exceed three thousand dollars per employee.

(c) Employees shall be eligible for bonuses for no more than two vesting periods, in an amount equal to but not greater than three thousand dollars per employee.

(d) Any bonus due and payable to an employee under this section shall be made by the employer no later than thirty days after the bonus is paid to the employer.

(e) No portion of any dollars received from claims under subparagraph (ii) of paragraph (b) of subdivision three of this section for employee bonuses shall be returned to any person other than the employee to whom the bonus is due or used to reduce the total compensation an employer is obligated to pay to an employee under section thirty-six hundred fourteen-c of the public health law, section six hundred fifty-two of the labor law, or any other provisions of law or regulations, or pursuant to any collectively bargained agreement.

(f) No portion of any bonus available pursuant to this subdivision shall be payable to a person who has been suspended or excluded under the medical assistance program during the vesting period and at the time an employer submits a claim under this section.

5. Audits, investigations and reviews. (a) The Medicaid inspector general shall, in coordination with the commissioner, conduct audits, investigations and reviews of employers required to submit claims under this section. Such claims, inappropriately paid, under this section shall constitute overpayments as that term is defined under the regulations governing the medical assistance program. The Medicaid inspector general may recover such overpayments to employers as it would an overpayment under the medical assistance program, impose sanctions up to and

including exclusion from the medical assistance program, impose penalties, and take any other action authorized by law where:

(i) an employer claims a bonus not due to an employee or a bonus amount in excess of the correct bonus amount due to an employee;

(ii) an employer claims, receives and fails to pay any part of the bonus due to a designated employee;

(iii) an employer fails to claim a bonus due to an employee.

(b) Any employer identified in paragraph (a) of this subdivision who fails to identify, claim and pay any bonus for more than ten percent of its employees eligible for the bonus shall also be subject to additional penalties under subdivision four of section one hundred forty-five-b of this article.

(c) Any employer who fails to pay any part of the bonus payment to a designated employee shall remain liable to pay such bonus to that employee, regardless of any recovery, sanction or penalty the Medicaid inspector general may impose.

(d) In all instances recovery of inappropriate bonus payments shall be recovered from the employer. The employer shall not have the right to recover any inappropriately paid bonus from the employee.

(e) Where the Medicaid inspector general sanctions an employer for violations under this section, they may also sanction any affiliates as defined under the regulations governing the medical assistance program.

6. Rules and regulations. The commissioner, in consultation with the Medicaid inspector general as it relates to subdivision five of this section, may promulgate rules, to implement this section pursuant to emergency regulation; provided, however, that this provision shall not be construed as requiring the commissioner to issue regulations to implement this section.

§ 2. Subparagraphs (iv) and (v) of paragraph (a) of subdivision 4 of section 145-b of the social services law, as amended by section 1 of part QQ of chapter 56 of the laws of 2020, are amended to read as follows:

(iv) such person arranges or contracts, by employment, agreement, or otherwise, with an individual or entity that the person knows or should know is suspended or excluded from the medical assistance program at the time such arrangement or contract regarding activities related to the medical assistance program is made[~~.~~];

(v) such person had an obligation to identify, claim, and pay a bonus under subdivision three of section three hundred sixty-seven-w of this article and such person failed to identify, claim and pay such bonus.

(vi) For purposes of this paragraph, "person" as used in subparagraph (i) of this paragraph does not include recipients of the medical assistance program; and "person" as used in subparagraphs (ii) [~~and~~], (iii) and (iv) of this paragraph, is as defined in paragraph (e) of subdivision [~~(6)~~] six of section three hundred sixty-three-d of this [~~chapter~~] article; and "person" as used in subparagraph (v) of this paragraph includes employers as defined in section three hundred sixty-seven-w of this article.

§ 3. Paragraph (c) of subdivision 4 of section 145-b of the social services law is amended by adding a new subparagraph (iii) to read as follows:

(iii) For subparagraph (v) of paragraph (a) of this subdivision, a monetary penalty shall be imposed for conduct described in subparagraphs (i), (ii) and (iii) of paragraph (a) of subdivision five of section three hundred sixty-seven-w of this article shall not exceed one thou-

sand dollars per failure to identify, claim and pay a bonus for each employee.

§ 4. Health care and mental hygiene worker bonuses for state employees. 1. An employee who is employed by a state operated facility, an institutional or direct-care setting operated by the executive branch of the State of New York or a public hospital operated by the state university of New York and who is deemed substantially equivalent to the definition of employee pursuant to paragraph (a) of subdivision 2 of section 367-w of the social services law as determined by the commissioner of health, in consultation with the chancellor of the state university of New York, the commissioner of the department of civil service, the director of the office of employee relations, and the commissioners of other state agencies, as applicable, and approved by the director of budget, shall be eligible for the health care and mental hygiene worker bonus. Such bonus shall only be paid to employees that receive an annualized base salary of one hundred thousand dollars or less.

2. Employees shall be eligible for health care and mental hygiene worker bonuses in an amount up to but not exceeding three thousand dollars per employee. The payment of bonuses shall be paid based on the total number of hours worked during two vesting periods based on the employee's start date with the employer. No employee's first vesting period may begin later than March thirty-first, two thousand twenty-three, and in total both vesting periods may not exceed one year in duration. For each vesting period, payments shall be in accordance with the following:

(a) employees who have worked an average of at least twenty but less than thirty hours per week over the course of a vesting period shall receive a five hundred dollar bonus for the vesting period;

(b) employees who have worked an average of at least thirty but less than thirty-seven and one half hours per week over the course of a vesting period shall receive a one thousand dollar bonus for such vesting period; and

(c) employees who have worked an average of at least thirty-seven and one half hours per week over the course of a vesting period shall receive a one thousand five hundred dollar bonus for such vesting period.

§ 5. An employee under this act shall be limited to a bonus of three thousand dollars per employee without regard to which section or sections such employee may be eligible.

§ 6. Notwithstanding any provision of law to the contrary, any bonus payment paid pursuant to this act, to the extent includible in gross income for federal income tax purposes, shall not be subject to state or local income tax.

§ 7. This act shall take effect immediately.

PART E

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

1. A state aid base grant shall be reimbursed to municipalities for the core public health services identified in section six hundred two of this title, in an amount of the greater of [~~sixty-five~~] one dollar and thirty cents per capita, [~~for each person in the municipality,~~] or [~~six hundred fifty thousand dollars~~] seven hundred fifty thousand dollars, provided that the municipality expends at least [~~six hundred fifty thou-~~

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

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

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

§ 3. Subdivisions 1 and 2 of section 616 of the public health law, subdivision 1 as amended by section 2 of part O of chapter 57 of the laws of 2019 and subdivision 2 as added by chapter 901 of the laws of 1986, are amended, and a new subdivision 4 is added to read as follows:

1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by subdivision two of section six hundred five of this article, no less than thirty-six per centum, except for the city of New York which shall receive no less than twenty per centum, **and reimbursement of a municipality's fringe benefit costs not to exceed a fringe benefit rate of fifty per centum as defined by subdivision four of this section,** of the difference between the amount of moneys expended by the municipality for eligible public health services pursuant to an approved application for state aid during the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article.

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

4. Moneys appropriated for the purposes of this article to a municipality may include reimbursement of a municipality's fringe benefits,

including but not limited to employee retirement funds, health insurance and federal old age and survivor's insurance.

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

PART F

Section 1. Section 3002 of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-a. The state emergency medical services council shall advise the commissioner on such issues as the commissioner may require related to the provision of emergency medical service, specialty care, designated facility care, and disaster medical care, and assist in the coordination of such. This shall include, but is not limited to, the recommendation, periodic revision, and application of rules and regulations, appropriateness review standards, treatment protocols, and quality improvement standards. The state emergency medical services council shall meet as frequently as determined necessary by the commissioner.

§ 2. Section 3003 of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-a. Each regional emergency medical services council shall advise the state emergency medical services council, the commissioner and the department on such issues as the state emergency medical services council, the commissioner and the department may require, related to the provision of emergency medical service, specialty care, designated facility care, and disaster medical care, and assist in the regional coordination of such.

§ 3. The public health law is amended by adding a new section 3004 to read as follows:

§ 3004. Emergency medical services quality and sustainability assurance program. The commissioner, with the advice of the state emergency medical advisory committee, may create an emergency medical services quality and sustainability assurance program. Standards and requirements of the quality and sustainability assurance program may include but not be limited to: clinical standards, quality metrics, safety standards, emergency vehicle operator standards, clinical competencies, sustainability metrics and minimum requirements for quality assurance and sustainability assurance programs to be followed by emergency medical services agencies, to promote positive patient outcomes, safety, and emergency medical services system sustainability throughout the state. The commissioner is hereby authorized to promulgate regulations related to the standards and requirements of the quality and sustainability assurance program. Quality and sustainability assurance programs shall require each emergency medical services agency to perform regular and periodic review of quality and sustainability assurance program metrics, identification of agency deficiencies and strengths, development of programs to improve agency metrics, strengthen system sustainability, and continuous monitoring of care provided. The department may contract for services to assist in the oversight of these metrics statewide with subject matter experts to assist in the oversight of these metrics statewide. The department may delegate authority to oversee these metrics and regulations to counties or other contractors as determined by the commissioner. Emergency medical services agencies that do not meet the standards and requirements set forth in the quality assurance program set by the commissioner may be subject to enforcement actions, including but not limited to revocation, suspension, perform-

ance improvement plans, or restriction from specific types of response such as but not limited to suspension of ability to respond to requests for emergency medical assistance or to perform emergency medical services.

§ 4. The public health law is amended by adding a new section 3018 to read as follows:

§ 3018. Statewide comprehensive emergency medical system plan. 1. The department, in consultation with the state emergency medical advisory committee, shall develop and maintain a statewide comprehensive emergency medical system plan that shall provide for a coordinated emergency medical system in New York state, including but not be limited to:

(a) Establishing a comprehensive statewide emergency medical system, incorporating facilities, transportation, workforce, communications, and other to improve the delivery of emergency medical service and thereby decrease morbidity, hospitalization, disability, and mortality;

(b) Improving the accessibility of high-quality emergency medical service;

(c) Coordinating professional medical organizations, hospitals, and other public and private agencies in developing approaches whereby persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be served appropriately and economically; and

(d) Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of emergency medical service practitioners training throughout New York state with emphasis on regions underserved by emergency medical services.

2. The statewide comprehensive emergency medical system plan shall be reviewed, updated if necessary, and published every five years on the department's website, or at such times as may be necessary to improve the effectiveness and efficiency of the state's emergency medical service system.

3. Each regional emergency medical advisory committee shall develop and maintain a comprehensive regional emergency medical system plan that shall provide for a coordinated emergency medical system within the region. Such plans shall be subject to review by the state emergency medical advisory committee and approval by the department.

4. Each county shall develop and maintain a comprehensive county emergency medical system plan that shall provide for a coordinated emergency medical system within the county. The county office of emergency medical services shall be responsible for the development and maintenance of the comprehensive county emergency medical system plan. Such plans shall be subject to review by the regional emergency medical advisory committee, the state advisory council and approval by the department. The department shall be responsible for oversight of each county's compliance with their plan.

5. The commissioner may promulgate regulations to ensure compliance with this section.

§ 5. The public health law is amended by adding a new section 3019 to read as follows:

§ 3019. Emergency medical systems training program. 1. There is hereby established a training program for emergency medical systems that includes students, emergency medical service practitioners, agencies, facilities, and personnel, and the commissioner may provide funding within the amount appropriated to conduct such training programs. Until such time as the department announces the training program pursuant to this section is in effect, all current standards, curriculums, and

requirements for students, emergency medical service practitioners, agencies, facilities, and personnel shall remain in effect.

2. The department, in consultation with the state emergency medical advisory council, shall establish minimum education standards, curriculums and requirements for all emergency medical system training programs. No person shall profess to provide emergency medical system training without the approval of the department.

3. The department is authorized to provide, either directly or through contract, emergency medical system training for emergency medical service practitioners and emergency medical system agency personnel, develop and distribute training materials for use by instructors, and to recruit additional instructors to provide training.

4. The department may visit and inspect any emergency medical system training program or training center operating under this article and the regulations adopted therefore to ensure compliance.

5. The commissioner shall, within amounts appropriated, establish a public service campaign to recruit additional personnel into the emergency medical system fields.

6. The commissioner shall, within amounts appropriated, establish an emergency medical system mental health and wellness program that provides resources to emergency medical service practitioners to reduce burnout, prevent suicides, and increase safety.

7. The department may create or adopt with the approval of the commissioner additional standards, training and criteria to become a credentialled emergency medical service practitioner to provide specialized, advanced, or other services that further support or advance the emergency medical system.

§ 6. Section 3008 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. (a) Notwithstanding any other provision of law, all determinations of need shall be consistent with the state emergency medical system plan established in section three thousand eighteen of this article. The commissioner may promulgate regulations to provide for the standards on the determination of need. The department shall issue a new emergency medical system agency certificate only upon a determination that a public need for the proposed service has been established pursuant to regulation. If the department determines that a public need exists for only a portion of a proposed service, a certificate may be issued for that portion. Prior to reaching a final determination of need, the department shall forward a summary of the proposed service including any documentation received or subsequent reports created thereto, to the state emergency medical services advisory council for review and recommendation to the department on the approval of the application. An applicant or other concerned party may appeal any determination made by the department pursuant to this section within fourteen days. Appeals shall be heard pursuant to the provisions of section twelve-a of this chapter, and a final determination as to need shall be made by the commissioner upon review of the report and recommendation of the presiding administrative law judge.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, the commissioner may promulgate regulations to provide for the issuance of an emergency medical system agency certificate without a determination of public need.

§ 7. Subdivision 1 of section 3001 of the public health law, as amended by chapter 804 of the laws of 1992, is amended to read as follows:

1. "Emergency medical service" means [~~initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies~~] care of a person to, from, at, in, or between the person's home, scene of injury, hospitals, health care facilities, public events or other locations, by emergency medical services practitioners as a patient care team member, for emergency, non-emergency, specialty, low acuity, preventative, or interfacility care; emergency and non-emergency medical dispatch; coordination of emergency medical system equipment and personnel; assessment; treatment, transportation, routing, referrals and communications with treatment facilities and medical personnel; public education, injury prevention and wellness initiatives; administration of immunizations as approved by the state emergency medical services council; and follow-up and restorative care.

§ 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.

PART G

Section 1. Notwithstanding any other provision of law, rule, or regulation to the contrary, the following articles of title 8 of the education law governing the healthcare professions are hereby REPEALED and all removed provisions, and all powers authorized pursuant to such provisions, are hereby added to the public health law under the authority of the commissioner of health, pursuant to a plan to be proposed not inconsistent with this section, which shall include the text of the new laws to be adopted.

Article 131 MEDICINE
Article 131-A DEFINITIONS OF PROFESSIONAL MISCONDUCT APPLICABLE TO PHYSICIANS, PHYSICIAN'S ASSISTANTS AND SPECIALIST'S ASSISTANTS
Article 131-B PHYSICIAN ASSISTANTS
Article 131-C SPECIALIST ASSISTANTS
Article 132 CHIROPRACTIC
Article 133 DENTISTRY, DENTAL HYGIENE, AND REGISTERED DENTAL ASSISTING
Article 134 LICENSED PERFUSIONISTS
Article 136 PHYSICAL THERAPY AND PHYSICAL THERAPIST ASSISTANTS
Article 137 PHARMACY
Article 137-A REGISTERED PHARMACY TECHNICIANS
Article 139 NURSING
Article 140 PROFESSIONAL MIDWIFERY PRACTICE ACT
Article 141 PODIATRY
Article 143 OPTOMETRY
Article 144 OPHTHALMIC DISPENSING
Article 153 PSYCHOLOGY
Article 154 SOCIAL WORK
Article 155 MASSAGE THERAPY
Article 156 OCCUPATIONAL THERAPY
Article 157 DIETETICS AND NUTRITION
Article 159 SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS
Article 160 ACUPUNCTURE
Article 162 ATHLETIC TRAINERS
Article 163 MENTAL HEALTH PRACTITIONERS
Article 164 RESPIRATORY THERAPISTS AND RESPIRATORY THERAPY TECHNICIANS
Article 165 CLINICAL LABORATORY TECHNOLOGY PRACTICE ACT
Article 166 MEDICAL PHYSICS PRACTICE
Article 167 APPLIED BEHAVIOR ANALYSIS

Article 168 LICENSED PATHOLOGISTS' ASSISTANTS

§ 2. Transfer of functions, powers, duties and obligations. Notwithstanding any inconsistent provisions of law to the contrary, effective January 1, 2023, all functions, powers, duties and obligations of the education department concerning the professions of medicine, physicians, physicians assistants, specialist assistants, chiropractic, dentistry, dental hygiene, registered dental assisting, perfusionists, physical therapy, physical therapy assistants, pharmacy, registered pharmacy technicians, nursing, professional midwifery, podiatry, optometry, ophthalmic dispensing, psychology, social work, massage therapy, occupational therapy, dietetics and nutrition, speech-language pathologists and audiologist, acupuncture, athletic trainers, mental health practitioners, respiratory therapists, respiratory therapy technicians, clinical laboratory technology, medical physics, applied behavior analysis, and licensed pathologists' assistants under title 8 of the education law shall be transferred to the New York state department of health.

§ 3. Transfer of records. All books, papers and property of the state education department with respect to the functions, powers and duties transferred by sections one through nine of this act are to be delivered to the appropriate offices within the department of health, at such place and time, and in such manner as the department of health requires.

§ 4. Continuity of authority. For the purpose of all functions, powers, duties and obligations of the state education department transferred to and assumed by the department of health, the department of health shall continue the operation of the provisions previously done by the state education department, pursuant to sections one through nine of this act.

§ 5. Completion of unfinished business. Any business or other matter undertaken or commenced by the state education department pertaining to or connected with the functions, powers, duties and obligations hereby transferred and assigned to the department of health and pending on the effective date of January 1, 2023 shall be conducted and completed by the department of health in the same manner and under the same terms and conditions and with the same effect as if conducted and completed by the state education department.

§ 6. Continuation of rules and regulations. All rules, regulations, acts, orders, determinations, and decisions of the state education department in force at the time of such transfer and assumption, shall continue in force and effect as rules, regulations, acts, orders, determinations and decisions of the department of health until duly modified or abrogated by the department of health.

§ 7. Terms occurring in laws, contracts and other documents. Whenever the state education department is referred to or designated in any law, contract or document pertaining to the functions, powers, obligations and duties hereby transferred and assigned, such reference or designation shall be deemed to refer to department of health or the commissioner thereof.

§ 8. Existing rights and remedies preserved. No existing right or remedy of any character shall be lost, impaired or affected by reason of sections one through nine of this act.

§ 9. Pending actions or proceedings. No action or proceeding pending at the time when sections one through nine of this act shall take effect relating to the functions, powers and duties of the state education department transferred pursuant to sections one through nine of this act, brought by or against the state education department or board of regents shall be affected by any provision of sections one through one

hundred forty of this act, but the same may be prosecuted or defended in the name of commissioner of the department of health. In all such actions and proceedings, the commissioner of health, upon application to the court, shall be substituted as a party.

§ 10. This act shall take effect January 1, 2023.

PART H

Section 1. Subdivision 1 of section 91 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 2 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

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

§ 2. Paragraph (a) of subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to relating to known and projected department of health state fund Medicaid expenditures, as amended by section 1 of part A of chapter 57 of the laws of 2021, is amended to read as follows:

(a) For state fiscal years 2011-12 through [~~2021-22~~] 2023-24, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a quarterly basis, as reflected in quarterly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner.

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

PART I

Section 1. 1. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2022 and ending on March 31, 2024, all department of health Medicaid payments made for services provided on and after April 1, 2022, shall be subject to a uniform rate increase of one percent, subject to the approval of the commissioner of the department of health and director of the budget. Such rate increase shall be subject to federal financial participation.

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

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

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

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

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

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

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

PART J

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

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

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

PART K

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

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

2. The commissioner shall enter into an agreement with the dormitory authority of the state of New York pursuant to section sixteen hundred eighty-r of the public authorities law, which shall apply to this agreement, subject to the approval of the director of the division of the budget, for the purposes of the distribution, and administration of available funds, pursuant to such agreement, and made available pursuant to this section and appropriation. Such funds may be awarded and distributed by the department for grants to health care facilities

including but not limited to, hospitals, residential health care facilities, adult care facilities licensed under title two of article seven of the social services law, diagnostic and treatment centers, and clinics licensed pursuant to this chapter or the mental hygiene law, children's residential treatment facilities licensed pursuant to article thirty-one of the mental hygiene law, assisted living programs approved by the department pursuant to section four hundred sixty-one-l of the social services law, behavioral health facilities licensed pursuant to articles thirty-one and thirty-two of the mental hygiene law, and independent practice associations or organizations. A copy of such agreement, and any amendments thereto, shall be provided by the department to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of the budget no later than thirty days after such agreement is finalized. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

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

(a) twenty-five million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article;

(b) twenty-five million dollars of total awarded funds shall be made to a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; independent practice associations or organizations; a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law; a home care provider certified or licensed pursuant to article thirty-six of this chapter; or hospices licensed or granted an operating certificate pursuant to article forty of this chapter; and

(c) fifty million dollars of total awarded funds shall be made to residential health care facilities or adult care facilities.

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

diseases, trauma or severe behavioral health issues from other patients in the emergency department; (c) provides training in emergency care and trauma care to residents from multiple hospitals in the region; and (d) serves a high proportion of Medicaid patients.

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

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

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

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

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

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

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

PART L

Section 1. Subdivision 3 of section 2801-a of the public health law, as amended by section 57 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

3. The public health and health planning council shall not approve a certificate of incorporation, articles of organization or application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the institution at the time and place and under the circumstances proposed, provided, however, that in the case of an institution proposed to be established or operated by an organization defined in subdivision one of section one hundred seventy-two-a of the executive law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need; (b) the character, competence, and standing in the community, of the proposed incorporators, directors, sponsors, stockholders, members, controlling persons, or operators; with respect to any proposed incorporator, director, sponsor, stockholder, member , controlling person, or operator who is already or within the past [~~ten~~] seven years [~~has~~] been an incorporator, director, sponsor, member, principal stockholder, principal member, controlling person, or operator any hospital or other health-related or long-term care facility, program or agency, including but not limited to, private proprietary home for adults, residence for adults, or non-profit home for the aged or blind which has been issued an operating certificate by the state department of social services, or a halfway house, hostel or other residential facility or institution for the care, custody or treatment of the mentally disabled which is subject to approval by the department of mental hygiene, no approval shall be granted unless the public health and health planning council, having afforded an adequate opportunity to members of health systems agencies, if any, having geographical jurisdiction of the area where the institution is to be located to be heard, shall affirmatively find by substantial evidence as to each such incorporator, director, sponsor, member, principal stockholder, principal member, controlling person, or operator that a substantially consistent high level of care is being or was being rendered in each such hospital, home, residence, halfway house, hostel, or other residential facility or institution [~~with~~] in which such person is or was affiliated; for the purposes of this paragraph, the public health and health planning council shall adopt rules and regulations, subject to the approval of the commissioner, to establish the criteria to be used to determine whether a substantially consistent high level of care has been rendered, provided, however, that there shall not be a finding that a substantially consistent high level of care has been rendered where there have been violations of the state hospital code, or other applicable rules and regulations, that (i) threatened to directly affect the health, safety or welfare of any patient or resident, and (ii) were recurrent or were not promptly corrected; (c) the financial resources of the proposed institution and its sources of future revenues; and (d) such other matters as it shall deem pertinent.

§ 2. Paragraphs (b) and (c) of subdivision 4 of section 2801-a of the public health law, as amended by section 57 of part A of chapter 58 of the laws of 2010, are amended to read as follows:

(b) [~~(i)~~] Any transfer, assignment or other disposition of [~~ten percent or more of~~] an interest, stock, or voting rights in a sole proprietorship, partnership [~~or~~], limited liability company, non-for-profit corporation, or corporation which is the operator of a hospital [~~to a new partner or member~~] or any transfer, assignment or other disposition which results in the ownership or control of an interest, stock, or voting rights in that operator, shall be approved by the public health and health planning council, in accordance with the provisions of

subdivisions two [~~and~~], three, and three-b of this section, except that: [~~(A) any such change shall be subject to the approval by the public~~]

(i) Public health and health planning council approval in accordance with paragraph (b) of [~~subdivision~~] subdivisions three and three-b of this section shall be required only with respect to [~~the new partner or member, and~~] any [~~remaining partners or members~~] person, partner, member, or stockholder who [~~have~~] has not been previously approved for that [~~facility~~] operator in accordance with [~~such paragraph, and (B) such change shall not be subject to paragraph (a) of subdivision three of this section~~] paragraph (b) of subdivision three and subdivision three-b of this section.

(ii) [~~With~~] Such change shall not be subject to the public need assessment described in paragraph (a) of subdivision three of this section.

(iii) No prior approval of the public health and health planning council shall be required with respect to a transfer, assignment or disposition [~~involving less than ten percent of~~], directly or indirectly, of: (A) an interest, stock, or voting rights of less than ten percent in [~~such partnership or limited liability company~~] the operator, to [~~a new~~] any person, partner [~~or~~], member, [~~no prior approval of the public health and health planning council shall be required~~] or stockholder who has not been previously approved by the public health and health planning council, or its predecessor for that operator. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the [~~partnership or limited liability company~~] operator fully completes and files with the public health and health planning council notice on a form, to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the department to recommend and for the public health and health planning council to determine whether it should bar the transaction for any of the reasons set forth in [~~item (A), (B), (C) or (D)~~] clause one, two, three or four below, and has fully responded to any request for additional information by the department acting on behalf of the public health and health planning council during the review period. Such transaction will be final upon completion of the review period, which shall be no longer than ninety days from the date the department receives a complete response to its final request for additional information, unless, prior thereto, the public health and health planning council has notified each party to the proposed transaction that it has barred such transactions. [~~Within ninety days from the date of receipt of such notice, the~~] The public health and health planning council may bar any transaction under this subparagraph: [~~(A)~~] (1) if the equity position of the partnership [~~or~~], limited liability company, or corporation that operates a hospital for profit, determined in accordance with generally accepted accounting principles, would be reduced as a result of the transfer, assignment or disposition; [~~(B)~~] (2) if the transaction would result in the ownership of a partnership or membership interest or stock by any persons who have been convicted of a felony described in subdivision five of section twenty-eight hundred six of this article; [~~(C)~~] (3) if there are reasonable grounds to believe that the proposed transaction does not satisfy the character and competence criteria set forth in subdivision three or three-b of this section; or [~~(D)~~] (4) if the transaction, together with all transactions under this subparagraph for the [~~partnership, or successor,~~] operator during any five year period would, in the aggregate, involve twenty-five percent or more of the interest in the [~~partnership~~] operator. The

public health and health planning council shall state specific reasons for barring any transaction under this subparagraph and shall so notify each party to the proposed transaction[~~.~~]; or

[~~(iii) With respect to a transfer, assignment or disposition of~~] (B) an interest, stock, or voting rights [~~in such partnership or limited liability company~~] to any [~~remaining~~] person, partner [~~or~~], member, [~~which transaction involves the withdrawal of the transferor from the partnership or limited liability company, no prior approval of the public health and health planning council shall be required~~] or stockholder, previously approved by the public health and health planning council, or its predecessor, for that operator. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the [~~partnership or limited liability company~~] operator fully completes and files with the public health and health planning council notice on a form, to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the department to recommend and for the public health and health planning council to determine whether it should bar the transaction for the reason set forth below, and has fully responded to any request for additional information by the department acting on behalf of the public health and health planning council during the review period. Such transaction will be final upon completion of the review period, which shall be no longer than ninety days from the date the department receives a complete response to its final request for additional information, unless, prior thereto, the public health and health planning council has notified each party to the proposed transaction that it has barred such transactions. [~~Within ninety days from the date of receipt of such notice, the~~] The public health and health planning council may bar any transaction under this subparagraph if the equity position of the partnership [~~or~~], limited liability company, or corporation that operates a hospital for profit, determined in accordance with generally accepted accounting principles, would be reduced as a result of the transfer, assignment or disposition. The public health and health planning council shall state specific reasons for barring any transaction under this subparagraph and shall so notify each party to the proposed transaction.

(c) [~~Any transfer, assignment or other disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the operator of a hospital or which is a member of a limited liability company which is the operator of a hospital to a new stockholder, or any transfer, assignment or other disposition of the stock or voting rights thereunder of such a corporation which results in the ownership or control of more than ten percent of the stock or voting rights thereunder of such corporation by any person not previously approved by the public health and health planning council, or its predecessor, for that corporation shall be subject to approval by the public health and health planning council, in accordance with the provisions of subdivisions two and three of this section and rules and regulations pursuant thereto; except that: any such transaction shall be subject to the approval by the public health and health planning council in accordance with paragraph (b) of subdivision three of this section only with respect to a new stockholder or a new principal stockholder; and shall not be subject to paragraph (a) of subdivision three of this section. In the absence of such approval, the operating certificate of such hospital shall be subject to revocation or suspension. No prior approval of the public health and health planning council shall be required with respect to a~~

~~transfer, assignment or disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the operator of a hospital or which is a member of a limited liability company which is the owner of a hospital to any person previously approved by the public health and health planning council, or its predecessor, for that corporation. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the stockholder completes and files with the public health and health planning council notice on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction. Such transaction will be final as of the intended effective date unless, prior thereto, the public health and health planning council shall state specific reasons for barring such transactions under this paragraph and shall notify each party to the proposed transaction.~~] Nothing in this [~~paragraph~~] **subdivision** shall be construed as permitting [~~a~~] **any** person**, partner, member, or stockholder** not previously approved by the public health and health planning council for that [~~corporation~~] **operator** to [~~become the owner of~~] **own or control, directly or indirectly,** ten percent or more of the **interest,** stock**, or voting rights** of [~~a~~] **any partnership, limited liability company, not-for-profit corporation, or** corporation which is the operator of a hospital or **a corporation** which is a member of a limited liability company which is the owner of a hospital without first obtaining the approval of the public health and health planning council. **In the absence of approval by the public health and health planning council as required under this subdivision, the operating certificate of such hospital shall be subject to revocation or suspension. Failure to provide notice as required under this subdivision may subject the operating certificate of such operator to revocation or suspension.**

§ 3. Section 3611-a of the public health law, as amended by section 92 of part C of chapter 58 of the laws of 2009, subdivisions 1 and 2 as amended by section 67 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

§ 3611-a. Change in the operator or owner. 1. Any [~~change in the person who, or any~~] transfer, assignment, or other disposition of an interest**, stock,** or voting rights [~~of ten percent or more~~] **in a sole proprietorship, partnership, limited liability company, not-for-profit corporation or corporation which is the operator of a licensed home care services agency or a certified home health agency**, or any transfer, assignment or other disposition which results in the ownership or control of an interest**, stock,** or voting rights [~~of ten percent or more,~~] in [~~a limited liability company or a partnership which is the~~] **that** operator [~~of a licensed home care services agency or a certified home health agency~~]**,** shall be approved by the public health and health planning council, in accordance with the provisions of subdivision four of section thirty-six hundred five of this article relative to licensure or subdivision two of section thirty-six hundred six of this article relative to certificate of approval, except that:

(a) Public health and health planning council approval shall be required only with respect to the person, [~~or the~~] **partner,** member or [~~partner~~] **stockholder** that is acquiring the interest**, stock,** or voting rights[~~; and~~]**.**

(b) With respect to certified home health agencies, such change shall not be subject to the public need assessment described in paragraph (a) of subdivision two of section thirty-six hundred six of this article.

(c) With respect to licensed home care services agencies, the commissioner may promulgate regulations directing whether such change shall be subject to the public need assessment described in paragraph (a) of subdivision four of section thirty-six hundred five of this article.

[~~(c)~~] (d) No prior approval of the public health and health planning council shall be required with respect to a transfer, assignment or disposition, directly or indirectly, of:

(i) an interest, stock, or voting rights to any person, partner, member, or stockholder previously approved by the public health and health planning council, or its predecessor, for that operator. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the operator completes and files with the public health and health planning council notice on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the department to recommend and for the public health and health planning council to determine whether it should bar the transaction, and has fully responded to any request for additional information by the department acting on behalf of the public health and health planning council during the review period. Such transaction will be final upon completion of the review period, which shall be no longer than ninety days from the date the department receives a complete response to its final request for additional information, unless, prior thereto, the public health and health planning council has notified each party to the proposed transaction that it has barred such transactions under this paragraph and has stated specific reasons for barring such transactions; or

(ii) an interest, stock, or voting rights of less than ten percent in the operator to any person, partner, member, or stockholder who has not been previously approved by the public health and health planning council for that operator. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the [~~partner or member~~] operator completes and files with the public health and health planning council notice on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the department to recommend and for the public health and health planning council to determine whether it should bar the transaction, and has fully responded to any request for additional information by the department acting on behalf of the public health and health planning council during the review period. Such transaction will be final [~~as of the intended effective date~~] upon completion of the review period, which shall be no longer than ninety days from the date the department receives a complete response to its final request for additional information, unless, prior thereto, the public health and health planning council [~~shall state~~] has notified each party to the proposed transaction that it has barred such transactions under this paragraph and has stated specific reasons for barring such transactions [~~under this paragraph and shall notify each party to the proposed transaction~~].

(iii) Nothing in this subdivision shall be construed as permitting any person, partner, member, or stockholder not previously approved by the public health and health planning council for that operator to own or control, directly or indirectly, ten percent or more of the interest, stock, or voting rights of any partnership, limited liability company, not-for-profit corporation, or corporation which is the operator of a licensed home care services agency or a certified home health agency

without first obtaining the approval of the public health and health planning council.

(iv) In the absence of approval by the public health and health planning council as required under this paragraph, the license or certificate of approval of such operator shall be subject to revocation or suspension. Failure to provide notice as required under this paragraph may subject the license or certificate of approval of such operator to revocation or suspension thereof.

2. [~~Any transfer, assignment or other disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the operator of a licensed home care services agency or a certified home health agency, or any transfer, assignment or other disposition of the stock or voting rights thereunder of such a corporation which results in the ownership or control of more than ten percent of the stock or voting rights thereunder of such corporation by any person shall be subject to approval by the public health and health planning council in accordance with the provisions of subdivision four of section thirty-six hundred five of this article relative to licensure or subdivision two of section thirty-six hundred six of this article relative to certificate of approval, except that:~~

~~(a) Public health and health planning council approval shall be required only with respect to the person or entity acquiring such stock or voting rights; and~~

~~(b) With respect to certified home health agencies, such change shall not be subject to the public need assessment described in paragraph (a) of subdivision two of section thirty-six hundred six of this article. In the absence of such approval, the license or certificate of approval shall be subject to revocation or suspension.~~

~~(c) No prior approval of the public health and health planning council shall be required with respect to a transfer, assignment or disposition of an interest or voting rights to any person previously approved by the public health and health planning council, or its predecessor, for that operator. However, no such transaction shall be effective unless at least one hundred twenty days prior to the intended effective date thereof, the partner or member completes and files with the public health and health planning council notice on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction. Such transaction will be final as of the intended effective date unless, prior thereto, the public health and health planning council shall state specific reasons for barring such transactions under this paragraph and shall notify each party to the proposed transaction.~~

~~3.~~] (a) The commissioner shall charge to applicants for a change in operator or owner of a licensed home care services agency or a certified home health agency an application fee in the amount of two thousand dollars.

(b) The fees paid by certified home health agencies pursuant to this subdivision for any application approved in accordance with this section shall be deemed allowable costs in the determination of reimbursement rates established pursuant to this article. All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue funds - other, miscellaneous special revenue fund - 339, certificate of need account.

§ 4. Paragraph (b) of subdivision 3 of section 4004 of the public health law, as amended by section 69 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

(b) Any [~~change in the person, principal stockholder or~~] transfer, assignment or other disposition, of an interest, stock, or voting rights in a sole proprietorship, partnership, limited liability company, not-for-profit corporation, or corporation which is the operator of a hospice, or any transfer, assignment or other disposition which results in the direct or indirect ownership or control of an interest, stock or voting rights in that operator, shall be approved by the public health and health planning council in accordance with the provisions of subdivisions one and two of this section[~~.~~]; provided, however:

(i) Public health and health planning council approval shall be required only with respect to the person, partner, member, or stockholder that is acquiring the interest, stock, or voting rights.

(ii) Such change shall not be subject to the public need assessment described in paragraph (a) of subdivision two of this section.

(iii) No prior approval of the public health and health planning council shall be required with respect to a transfer, assignment or disposition, directly or indirectly, of:

(A) an interest, stock, or voting rights to any person, partner, member, or stockholder previously approved by the public health and health planning council, or its predecessor, for that operator. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the operator completes and files with the public health and health planning council notice, on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the department to recommend and for the public health and health planning council to determine whether it should bar the transaction, and has fully responded to any request for additional information by the department acting on behalf of the public health and health planning council during the review period. Such transaction will be final upon completion of the review period, which shall be no longer than ninety days from the date the department receives a complete response to its final request for additional information, unless, prior thereto, the public health and health planning council has notified each party to the proposed transaction that it has barred such transactions under this paragraph and has stated specific reasons for barring such transactions; or

(B) an interest, stock, or voting rights of less than ten percent in the operator to any person, partner, member, or stockholder who has not been previously approved by the public health and health planning council for that operator. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the operator completes and files with the public health and health planning council notice on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the department to recommend and for the public health and health planning council to determine whether it should bar the transaction, and has fully responded to any request for additional information by the department acting on behalf of the public health and health planning council during the review period. Such transaction will be final upon completion of the review period, which shall be no longer than ninety days from the date the department receives a complete response to its final request for additional information, unless, prior thereto, the public health and health planning council has

notified each party to the proposed transaction that it has barred such transactions under this paragraph and has stated specific reasons for barring such transactions.

(iv) Nothing in this subdivision shall be construed as permitting any person, partner, member, or stockholder not previously approved by the public health and health planning council for that operator to own or control, directly or indirectly, ten percent or more of the interest, stock, or voting rights of any partnership, limited liability company, not-for-profit corporation, or corporation which is the operator of a hospice without first obtaining the approval of the public health and health planning council.

(v) In the absence of approval by the public health and health planning council as required under this paragraph, the certificate of approval of such operator shall be subject to revocation or suspension. Failure to provide notice as required under this paragraph may subject the certificate of approval of such operator to revocation or suspension.

§ 5. This act shall take effect immediately.

PART M

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

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

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

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

(iii) the capital per diem portion of the reimbursement rate for nursing homes that have a four- or five-star rating assigned pursuant to the inspection rating system of the U.S. Centers for Medicare and Medicaid Services (CMS rating).

§ 2. Subdivision 4 of section 2828 of the public health law, as added by section 1 of part GG of chapter 57 of the laws of 2021, is amended to read as follows:

4. The commissioner may waive the requirements of this section on a case-by-case basis with respect to a nursing home that demonstrates to the commissioner's satisfaction that it experienced unexpected or exceptional circumstances that prevented compliance. The commissioner may also exclude from revenues and expenses, on a case-by-case basis, extraordinary revenues and capital expenses, incurred due to a natural disaster or other circumstances set forth by the commissioner in regulation. The commissioner may also exclude from revenues, on a case-by-case basis, the capital per diem portion of the reimbursement rate for nursing homes that have a three-star CMS rating. At least thirty days before any action by the commissioner under this subdivision, the

commissioner shall transmit the proposed action to the state office of the long-term care ombudsman and the chairs of the senate and assembly health committees, and post it on the department's website.

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

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

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

Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand [~~fifteen~~] **twenty-two** through March thirty-first, two thousand [~~sixteen~~] **twenty-three**, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible [~~general hospitals~~] **facilities** in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services. **Provided, however, the commissioner is authorized to make such a temporary adjustment or make such temporary lump sum payment only pursuant to criteria, an evaluation process, and transformation plan acceptable to the commissioner in consultation with the director of the division of the budget.**

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

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

(B) a federally designated critical access hospital;

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

(D) **a residential health care facility;**

(E) an adult care facility;

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

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

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

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

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

PART N

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

(4) An individual who is a pregnant woman or is a member of a family that contains a dependent child living with a parent or other caretaker relative is eligible for standard coverage if [~~his or her MAGI~~] their household income does not exceed [~~the MAGI equivalent of~~] one hundred [~~thirty~~] thirty-three percent of the [~~highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven~~] federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the Secretary of the United States department of health and human services; for purposes of this subparagraph, the term dependent child means a person who is under eighteen years of age, or is eighteen years of age and a full-time student, who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by reason of the unemployment of the parent, as defined by the department of health.

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

(2) An individual who, although not receiving public assistance or care for [~~his or her~~] their maintenance under other provisions of this chapter, has income [~~and resources~~], including available support from responsible relatives, that does not exceed the amounts set forth in paragraph (a) of subdivision two of this section, and is (i) sixty-five years of age or older, or certified blind or certified disabled or (ii) for reasons other than income [~~or resources~~], is eligible for federal supplemental security income benefits and/or additional state payments.

§ 3. Subparagraph 5 of paragraph (c) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(5) A disabled individual at least sixteen years of age, but under the age of sixty-five, who: would be eligible for benefits under the supple-

mental security income program but for earnings in excess of the allowable limit; has net available income that does not exceed two hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, for a one-person or two-person household, as defined by the commissioner in regulation; [~~has household resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, other than retirement accounts, that do not exceed twenty thousand dollars for a one-person household or thirty thousand dollars for a two-person household, as defined by the commissioner in regulation;~~] and contributes to the cost of medical assistance provided pursuant to this subparagraph in accordance with subdivision twelve of section three hundred sixty-seven-a of this title; for purposes of this subparagraph, disabled means having a medically determinable impairment of sufficient severity and duration to qualify for benefits under section 1902(a)(10)(A)(ii)(xv) of the social security act.

§ 4. Subparagraph 10 of paragraph (c) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(10) A resident of a home for adults operated by a social services district, or a residential care center for adults or community residence operated or certified by the office of mental health, and has not, according to criteria promulgated by the department consistent with this title, sufficient income, or in the case of a person sixty-five years of age or older, certified blind, or certified disabled, sufficient income [~~and resources~~], including available support from responsible relatives, to meet all the costs of required medical care and services available under this title.

§ 5. Paragraph (a) of subdivision 2 of section 366 of the social services law, as separately amended by chapter 32 and 588 of the laws of 1968, the opening paragraph as amended by chapter 41 of the laws of 1992, subparagraph 1 as amended by section 27 of part C of chapter 109 of the laws of 2006, subparagraphs 3 and 6 as amended by chapter 938 of the laws of 1990, subparagraph 4 as amended by section 43 and subparagraph 7 as amended by section 47 of part C of chapter 58 of the laws of 2008, subparagraph 5 as amended by chapter 576 of the laws of 2007, subparagraph 9 as amended by chapter 110 of the laws of 1971, subparagraph 10 as added by chapter 705 of the laws of 1988, clauses (i) and (ii) of subparagraph 10 as amended by chapter 672 of the laws of 2019, clause (iii) of subparagraph 10 as amended by chapter 170 of the laws of 1994, and subparagraph 11 as added by chapter 576 of the laws of 2015, is amended to read as follows:

(a) The following [~~income and resources~~] shall be exempt and shall not be taken into consideration in determining a person's eligibility for medical care, services and supplies available under this title:

(1) (i) for applications for medical assistance filed on or before December thirty-first, two thousand five, a homestead which is essential and appropriate to the needs of the household;

(ii) for applications for medical assistance filed on or after January first, two thousand six, a homestead which is essential and appropriate to the needs of the household; provided, however, that in determining eligibility of an individual for medical assistance for nursing facility services and other long term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the homestead exceeds seven hundred fifty thousand dollars; provided further, that the dollar amount specified in this clause shall be

increased, beginning with the year two thousand eleven, from year to year, in an amount to be determined by the secretary of the federal department of health and human services, based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest one thousand dollars. If such secretary does not determine such an amount, the department of health shall increase such dollar amount based on such increase in the consumer price index. Nothing in this clause shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the homestead. The home equity limitation established by this clause shall be waived in the case of a demonstrated hardship, as determined pursuant to criteria established by such secretary. The home equity limitation shall not apply if one or more of the following persons is lawfully residing in the individual's homestead: (A) the spouse of the individual; or (B) the individual's child who is under the age of twenty-one, or is blind or permanently and totally disabled, as defined in section 1614 of the federal social security act.

(2) [~~essential personal property;~~

~~(3) a burial fund, to the extent allowed as an exempt resource under the cash assistance program to which the applicant is most closely related;~~

~~(4) savings in amounts equal to one hundred fifty percent of the income amount permitted under subparagraph seven of this paragraph, provided, however, that the amounts for one and two person households shall not be less than the amounts permitted to be retained by households of the same size in order to qualify for benefits under the federal supplemental security income program;~~

~~(5)~~] (i) such income as is disregarded or exempt under the cash assistance program to which the applicant is most closely related for purposes of this subparagraph, cash assistance program means either the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six, or the supplemental security income program; and

(ii) such income of a disabled person (as such term is defined in section 1614(a)(3) of the federal social security act (42 U.S.C. section 1382c(a)(3)) or in accordance with any other rules or regulations established by the social security administration), that is deposited in trusts as defined in clause (iii) of subparagraph two of paragraph (b) of this subdivision in the same calendar month within which said income is received;

[~~(6)~~] **(3)** health insurance premiums;

[~~(7)~~] **(4)** income based on the number of family members in the medical assistance household, as defined in regulations by the commissioner consistent with federal regulations under title XIX of the federal social security act [~~and calculated as follows:~~

~~(i) The amounts for one and two person households and families shall be equal to twelve times the standard of monthly need for determining eligibility for and the amount of additional state payments for aged, blind and disabled persons pursuant to section two hundred nine of this article rounded up to the next highest one hundred dollars for eligible individuals and couples living alone, respectively.~~

~~(ii) The amounts for households of three or more shall be calculated by increasing the income standard for a household of two, established pursuant to clause (i) of this subparagraph, by fifteen percent for each additional household member above two, such that the income standard for a three-person household shall be one hundred fifteen percent of the~~

~~income standard for a two-person household, the income standard for a four-person household shall be one hundred thirty percent of the income standard for a two-person household, and so on.~~

~~(iii)~~] that does not exceed one hundred thirty-eight percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the United States secretary for health and human services;

(5) No other income [~~or resources~~], including federal old-age, survivors and disability insurance, state disability insurance or other payroll deductions, whether mandatory or optional, shall be exempt and all other income [~~and resources~~] shall be taken into consideration and required to be applied toward the payment or partial payment of the cost of medical care and services available under this title, to the extent permitted by federal law.

[~~(9) Subject to subparagraph eight, the~~] (6) The department, upon the application of a local social services district, after passage of a resolution by the local legislative body authorizing such application, may adjust the income exemption based upon the variations between cost of shelter in urban areas and rural areas in accordance with standards prescribed by the United States secretary of health, education and welfare.

[~~(10)~~] (7) (i) A person who is receiving or is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:

(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law, the amount of fifty-five dollars per month;

(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office for people with developmental disabilities or a patient of a hospital operated by the office of mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law, the amount of thirty-five dollars per month.

(ii) A person who neither receives nor is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:

(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law, the amount of fifty dollars per month;

(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office for people with developmental disabilities or a patient of a hospital operated by the office of mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law, the amount of thirty-five dollars per month.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the personal needs allowance for a person who is a veteran having neither a spouse nor a child, or a surviving spouse of a veteran having no child, who receives a reduced pension from the federal veterans administration, and who is a resident of a nursing facility, as defined in section 1919 of the federal social security act, shall be equal to such reduced monthly pension but shall not exceed ninety dollars per month.

[~~(11)~~] (8) subject to the availability of federal financial participation, any amount, including earnings thereon, in a qualified NY ABLE account as established pursuant to article eighty-four of the mental hygiene law, any contributions to such NY ABLE account, and any distribution for qualified disability expenses from such account; provided

however, that such exemption shall be consistent with section 529A of the Internal Revenue Code of 1986, as amended.

§ 6. Subparagraphs 1 and 2 of paragraph (b) of subdivision 2 of section 366 of the social services law, subparagraph 1 as amended by chapter 638 of the laws of 1993 and as designated by chapter 170 of the laws of 1994, subparagraph 2 as added by chapter 170 of the laws of 1994, clause (iii) of subparagraph 2 as amended by chapter 187 of the laws of 2017, clause (iv) of subparagraph 2 as amended by chapter 656 of the laws of 1997 and as further amended by section 104 of part A of chapter 62 of the laws of 2011, and clause (vi) of subparagraph 2 as added by chapter 435 of the laws of 2018, are amended to read as follows:

(1) In establishing standards for determining eligibility for and amount of such assistance, the department shall take into account only such income [~~and resources~~], in accordance with federal requirements, as [~~are~~] is available to the applicant or recipient and as would not be required to be disregarded or set aside for future needs, and there shall be a reasonable evaluation of any such income [~~or resources~~]. The department shall not consider the availability of an option for an accelerated payment of death benefits or special surrender value pursuant to paragraph one of subsection (a) of section one thousand one hundred thirteen of the insurance law, or an option to enter into a viatical settlement pursuant to the provisions of article seventy-eight of the insurance law, as an available resource in determining eligibility for an amount of such assistance, provided, however, that the payment of such benefits shall be considered in determining eligibility for and amount of such assistance. There shall not be taken into consideration the financial responsibility of any individual for any applicant or recipient of assistance under this title unless such applicant or recipient is such individual's spouse or such individual's child who is under twenty-one years of age. In determining the eligibility of a child who is categorically eligible as blind or disabled, as determined under regulations prescribed by the social security act for medical assistance, the income [~~and resources~~] of parents or spouses of parents are not considered available to that child if she/he does not regularly share the common household even if the child returns to the common household for periodic visits. In the application of standards of eligibility with respect to income, costs incurred for medical care, whether in the form of insurance premiums or otherwise, shall be taken into account. Any person who is eligible for, or reasonably appears to meet the criteria of eligibility for, benefits under title XVIII of the federal social security act shall be required to apply for and fully utilize such benefits in accordance with this chapter.

(2) In evaluating the income [~~and resources~~] available to an applicant for or recipient of medical assistance, for purposes of determining eligibility for and the amount of such assistance, the department must consider assets [~~held in or~~] paid from trusts created by such applicant or recipient, as determined pursuant to the regulations of the department, in accordance with the provisions of this subparagraph.

(i) In the case of a revocable trust created by an applicant or recipient, as determined pursuant to regulations of the department[~~: the trust corpus must be considered to be an available resource;~~], payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant

or recipient for purposes of paragraph (d) of subdivision five of this section.

(ii) In the case of an irrevocable trust created by an applicant or recipient, as determined pursuant to regulations of the department: any portion of the trust corpus, and of the income generated by the trust corpus, from which no payment can under any circumstances be made to such applicant or recipient must be considered, as of the date of establishment of the trust, or, if later, the date on which payment to the applicant or recipient is foreclosed, to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section; [~~any portion of the trust corpus, and of the income generated by the trust corpus, from which payment could be made to or for the benefit of such applicant or recipient must be considered to be an available resource;~~] payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, in the case of an applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act, the department must not consider as available income [~~or resources~~] the [~~corpus or~~] income of the following trusts which comply with the provisions of the regulations authorized by clause (iv) of this subparagraph: (A) a trust containing the assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age by the individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual; (B) and a trust containing the assets of such a disabled individual established and managed by a non-profit association which maintains separate accounts for the benefit of disabled individuals, but, for purposes of investment and management of trust funds, pools the accounts, provided that accounts in the trust fund are established solely for the benefit of individuals who are disabled as such term is defined in section 1614(a)(3) of the federal social security act by such disabled individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, and to the extent that amounts remaining in the individual's account are not retained by the trust upon the death of the individual, the state will receive all such remaining amounts up to the total value of all medical assistance paid on behalf of such individual. Notwithstanding any law to the contrary, a not-for-profit corporation may, in furtherance of and as an adjunct to its corporate purposes, act as trustee of a trust for persons with disabilities established pursuant to this subclause, provided that a trust company, as defined in subdivision seven of section one hundred-c of the banking law, acts as co-trustee.

(iv) The department shall promulgate such regulations as may be necessary to carry out the provisions of this subparagraph. Such regulations shall include provisions for: assuring the fulfillment of fiduciary obligations of the trustee with respect to the remainder interest of the department or state; monitoring pooled trusts; applying this subdivision to legal instruments and other devices similar to trusts, in accordance with applicable federal rules and regulations; and establishing procedures under which the application of this subdivision will be waived

with respect to an applicant or recipient who demonstrates that such application would work an undue hardship on him or her, in accordance with standards specified by the secretary of the federal department of health and human services. Such regulations may require: notification of the department of the creation or funding of such a trust for the benefit of an applicant for or recipient of medical assistance; notification of the department of the death of a beneficiary of such a trust who is a current or former recipient of medical assistance; in the case of a trust, the corpus of which exceeds one hundred thousand dollars, notification of the department of transactions tending to substantially deplete the trust corpus; notification of the department of any transactions involving transfers from the trust corpus for less than fair market value; the bonding of the trustee when the assets of such a trust equal or exceed one million dollars, unless a court of competent jurisdiction waives such requirement; and the bonding of the trustee when the assets of such a trust are less than one million dollars, upon order of a court of competent jurisdiction. The department, together with the department of financial services, shall promulgate regulations governing the establishment, management and monitoring of trusts established pursuant to subclause (B) of clause (iii) of this subparagraph in which a not-for-profit corporation and a trust company serve as co-trustees.

(v) Notwithstanding any acts, omissions or failures to act of a trustee of a trust which the department or a local social services official has determined complies with the provisions of clause (iii) and the regulations authorized by clause (iv) of this subparagraph, the department must not consider the [~~corpus or~~] income of any such trust as available income [~~or resources~~] of the applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act. The department's remedy for redress of any acts, omissions or failures to act by such a trustee which acts, omissions or failures are considered by the department to be inconsistent with the terms of the trust, contrary to applicable laws and regulations of the department, or contrary to the fiduciary obligations of the trustee shall be the commencement of an action or proceeding under subdivision one of section sixty-three of the executive law to safeguard or enforce the state's remainder interest in the trust, or such other action or proceeding as may be lawful and appropriate as to assure compliance by the trustee or to safeguard and enforce the state's remainder interest in the trust.

(vi) The department shall provide written notice to an applicant for or recipient of medical assistance who is or reasonably appears to be eligible for medical assistance except for having income exceeding applicable income levels. The notice shall inform the applicant or recipient, in plain language, that in certain circumstances the medical assistance program does not count the income of disabled applicants and recipients if it is placed in a trust described in clause (iii) of this subparagraph. The notice shall be included with the eligibility notice provided to such applicants and recipients and shall reference where additional information may be found on the department's website. This clause shall not be construed to change any criterion for eligibility for medical assistance.

§ 7. Paragraph (a) of subdivision 3 of section 366 of the social services law, as amended by chapter 110 of the laws of 1971, is amended to read as follows:

(a) Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with suffi-

cient income [~~and resources~~] to provide medical assistance as determined by the regulations of the department, the income [~~and resources~~] of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three **of this chapter** and other applicable provisions of law.

§ 8. Paragraph h of subdivision 6 of section 366 of the social services law, as amended by section 69-b of part C of chapter 58 of the laws of 2008, is amended to read as follows:

h. Notwithstanding any other provision of this chapter or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph b of this subdivision, the income [~~and resources~~] of responsible relatives shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

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

(vii) be ineligible for medical assistance because the income [~~and resources~~] of responsible relatives are deemed available to him or her, causing him or her to exceed the income or resource eligibility level for such assistance;

§ 10. Paragraph j of subdivision 7 of section 366 of the social services law, as amended by chapter 324 of the laws of 2004, is amended to read as follows:

j. Notwithstanding any other provision of this chapter other than subdivision six of this section or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph b of this subdivision, the income [~~and resources~~] of a responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

§ 11. Subdivision 8 of section 366 of the social services law, as added by chapter 41 of the laws of 1992, is amended to read as follows:

8. Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, income [~~and resources~~] which are otherwise exempt from consideration in determining a person's eligibility for medical care, services and supplies available under this title, shall be considered available for the payment or part payment of the costs of such medical care, services and supplies as required by federal law and regulations.

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

(vi) be eligible or, if discharged, would be eligible for medical assistance, or are ineligible for medical assistance because the income [~~and resources~~] of responsible relatives are or, if discharged, would be deemed available to such persons causing them to exceed the income [~~or resource~~] eligibility level for such assistance;

§ 13. Paragraph k of subdivision 9 of section 366 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

k. Notwithstanding any provision of this chapter other than subdivision six or seven of this section, or any other law to the contrary, for

purposes of determining medical assistance eligibility for persons specified in paragraphs b and c of this subdivision, the income [~~and resources~~] of a responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

§ 14. Paragraph (d) of subdivision 12 of section 366 of the social services law, as added by section 1 of part E of chapter 58 of the laws of 2006, is amended to read as follows:

(d) Notwithstanding any provision of this chapter or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph (b) of this subdivision, the income [~~and resources~~] of a legally responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision; provided, however, that such income shall continue to be deemed unavailable should responsibility for the care and placement of the person be returned to [~~his or her~~] **their** parent or other legally responsible person.

§ 15. Paragraph (b) of subdivision 2 of section 366-a of the social services law is REPEALED and paragraphs (c) and (d), paragraph (d) as added by section 29 of part B of chapter 58 of the laws of 2010, are relettered paragraphs (b) and (c).

§ 16. Paragraph (c) of subdivision 2 of section 366-a of the social services law, as added by section 29 of part B of section 58 of the laws of 2010 and as relettered by section fifteen of this act, is amended to read as follows:

(c) Notwithstanding the provisions of paragraph (a) of this subdivision, an applicant or recipient [~~whose eligibility under this title is determined without regard to the amount of his or her accumulated resources~~] may attest to the amount of interest income generated by [~~such~~] resources if the amount of such interest income is expected to be immaterial to medical assistance eligibility, as determined by the commissioner of health. In the event there is an inconsistency between the information reported by the applicant or recipient and any information obtained by the commissioner of health from other sources and such inconsistency is material to medical assistance eligibility, the commissioner of health shall request that the applicant or recipient provide adequate documentation to verify [~~his or her~~] **their** interest income.

§ 17. Paragraph (d) of subdivision 2 of section 366-a of the social services law is REPEALED.

§ 18. Paragraph (a) of subdivision 8 of section 366-a of the social services law, as amended by section 7 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(a) Notwithstanding subdivisions two and five of this section, information concerning income [~~and resources~~] of applicants for and recipients of medical assistance may be verified by matching client information with information contained in the wage reporting system established by section one hundred seventy-one-a of the tax law and in similar systems operating in other geographically contiguous states, by means of an income verification performed pursuant to a memorandum of understanding with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law, and, to the extent required by federal law, with information contained in the non-wage income file maintained by the United States internal revenue service, in the beneficiary data exchange maintained by the United States department of health and human services, and in the unemployment insurance benefits file. Such matching shall provide for procedures which document significant inconsistent results of matching activities.

Nothing in this section shall be construed to prohibit activities the department reasonably believes necessary to conform with federal requirements under section one thousand one hundred thirty-seven of the social security act.

§ 19. Subdivision 1 of section 366-c of the social services law, as added by chapter 558 of the laws of 1989, is amended to read as follows:

1. Notwithstanding any other provision of law to the contrary, in determining the eligibility for medical assistance of a person defined as an institutionalized spouse, the income [~~and resources~~] of such person and the person's community spouse shall be treated as provided in this section.

§ 20. Paragraphs (c), (d) and (e) of subdivision 2 of section 366-c of the social services law are REPEALED and paragraphs (f), (g), (h), (i), (j) and (k) of subdivision 2 are relettered paragraphs (c), (d), (e), (f), (g) and (h).

§ 21. Subdivisions 5 and 6 of section 366-c of the social services law are REPEALED and subdivisions 7 and 8 are renumbered subdivisions 5 and 6.

§ 22. Subdivisions 5 and 6 of section 366-c of the social services law, as added by chapter 558 of the laws of 1989 and as relettered by section twenty-one of this act, are amended to read as follows:

5. (a) At the beginning or after the commencement of a continuous period of institutionalization, either spouse may request [~~an assessment of the total value of their resources or~~] a determination of the community spouse monthly income allowance, the amount of the family allowance, or the method of computing the amount of the family allowance, or the method of computing the amount of the community spouse income allowance.

(b) [~~(i) Upon receipt of a request pursuant to paragraph (a) of this subdivision together with all relevant documentation of the resources of both spouses, the social services district shall assess and document the total value of the spouses' resources and provide each spouse with a copy of the assessment and the documentation upon which it was based. If the request is not part of an application for medical assistance benefits, the social services district may charge a fee for the assessment which is related to the cost of preparing and copying the assessment and documentation which fee may not exceed twenty-five dollars.~~

~~(ii) The social services district shall also notify each requesting spouse of the community spouse monthly income allowance, of the amount, if any, of the family allowances, and of the method of computing the amount of the community spouse monthly income allowance.~~

~~(c)~~] The social services district shall also provide to the spouse a notice of the right to a fair hearing at the time of provision of the information requested under paragraph (a) of this subdivision or after a determination of eligibility for medical assistance. Such notice shall be in the form prescribed or approved by the commissioner and include a statement advising the spouse of the right to a fair hearing under this section.

6. (a) If, after a determination on an application for medical assistance has been made, either spouse is dissatisfied with the determination of the community spouse monthly allowance[~~,~~] **or** the amount of monthly income otherwise available to the community spouse, [~~the computation of the spousal share of resources, the attribution of resources or the determination of the community spouse's resource allocation,~~] the spouse may request a fair hearing to dispute such determination. Such hearing shall be held within thirty days of the request therefor.

(b) If either spouse establishes that the community spouse needs income above the level established by the social services district as the minimum monthly maintenance needs allowance, based upon exceptional circumstances which result in significant financial distress (as defined by the commissioner in regulations), the department shall substitute an amount adequate to provide additional necessary income from the income otherwise available to the institutionalized spouse.

[~~(c) If either spouse establishes that income generated by the community spouse resource allowance, established by the social services district, is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, the department shall establish a resource allowance for the spousal share of the institutionalized spouse adequate to provide such minimum monthly maintenance needs allowance.~~]

§ 23. The commissioner of health shall, consistent with the social services law, make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three of the social services law, in order to ensure federal financial participation in expenditures under the provisions of this act. The provisions of this act shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of services provide hereunder.

§ 24. This act shall take effect January 1, 2023, subject to federal financial participation; provided, however that the amendments to paragraph h of subdivision 6 of section 366 of the social services law made by section eight of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith; provided further that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of federal financial participation 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 O

Section 1. Subdivision 3 of section 367-r of the social services law, as added by section 2 of part PP of chapter 56 of the laws of 2020, is amended and a new subdivision 4 is added to read as follows:

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

4. Medically fragile adults. (a) The commissioner shall increase rates for private duty nursing services that are provided to medically fragile adults, as such term is defined by the commissioner in regulation, to ensure the availability of such services to such adults. In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile adults in a non-institutional setting as compared to an institutional setting. Such increased rates for services rendered to such adults may take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the private duty nursing service is provided, costs associated with the provision of private duty nursing services to medically fragile adults, and the need for incentives to improve services and institute economies and such increased rates shall be payable only to those private duty nurses who can demonstrate, to the satisfaction of the department of health, satisfactory training and experience to provide services to such adults. Such increased rates shall be determined based on application of the case mix adjustment factor for AIDS home care program services rates as determined pursuant to applicable regulations of the department of health. The commissioner may promulgate regulations to implement the provisions of this subdivision.

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

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

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

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

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

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

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

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

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

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

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

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

§ 3. The public health law is amended by adding a new article 29-EE to read as follows:

ARTICLE 29-EE
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

§ 2999-s. Definitions. For the purposes of this article, the following terms shall have the following meanings:

1. "PACE organization" means a PACE provider, as defined in 42 U.S.C. § 1395(eee), established in accordance with federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, including amendments thereto.

2. "Program of all-inclusive care for the elderly", "PACE" or "PACE program" shall include those programs defined as "operating demonstrations" by section forty-four hundred three-f of this chapter.

3. "PACE center" means a facility established in accordance with regulations promulgated hereunder that is operated by a PACE organization where primary care and other services are furnished to enrollees of such program.

§ 2999-t. PACE organization establishment. 1. Notwithstanding any inconsistent provision to the contrary, the commissioner shall establish a program for all-inclusive care for the elderly in New York, to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medicaid state plan and any applicable waivers, as well as under contracts entered into between the federal centers for Medicare and Medicaid services, the department, and PACE organizations.

2. The establishment of such a program shall not preclude the continued operation of existing approved PACE organizations at the time of enactment or implementation of this article. The department may establish a process, if deemed necessary, to assist the transition of such existing programs through processes and requirements set forth pursuant to this article.

§ 2999-u. Criteria for program eligibility and licensure. 1. Program criteria. The requirements of the PACE model, as provided for pursuant to 42 U.S.C. § 1395(eee) and 42 U.S.C. § 1396(u-4), including amendments thereto, shall not be waived or modified. New York state PACE organization requirements shall include, but not be limited to:

(a) The provision and maintenance of a PACE center; and

(b) The adoption and implementation of an interdisciplinary team approach to care management, care delivery, and care planning.

2. Contracting. (a) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and sections one hundred forty-two and one hundred forty-three of the economic development law, the department may enter into contracts, including amendments or extensions thereto, with public or private organizations that meet the standards for licensure established under this article and under any process established to assist in the transition of existing programs, for implementation and operation of a PACE organization.

(b) The department may enter into additional contracts as necessary to implement, operate or oversee the program, or any other contracts deemed necessary to provide comprehensive community-based, risk-based and capitated long-term care to eligible populations under the PACE program.

(c) PACE organizations shall contract with the federal centers for Medicare and Medicaid services to enter into a PACE organization agreement.

3. Licensure. (a) In setting forth requirements to establish the state's PACE organization, the department shall provide for a unified licensure process for PACE organizations that is inclusive of program requirements set forth under articles twenty-eight, thirty-six, and forty-four of this chapter, as well as pertinent regulatory requirements

for PACE organizations in accordance with a regulatory approach which shall be established by the department.

(b) An entity may not operate a PACE organization in the state without being licensed in accordance with this subdivision and any regulations promulgated hereunder; provided, however, that this requirement shall not be construed to disallow the operation of approved PACE organizations at the time of enactment or implementation of this act in accordance with any process established by the department to assist the transition of such existing programs through processes and requirements set forth in accordance with this article.

4. Operations and oversight. The department shall:

(a) Establish requirements for financial solvency for PACE organizations in compliance with those set forth in paragraph (c) of subdivision one of section forty-four hundred three of this chapter, and shall establish a contingent reserve requirement for PACE organizations which, pursuant to regulations, may be different than other plans;

(b) Provide oversight of PACE organization operations in coordination with the centers for Medicare and Medicaid services, including the establishment of any rules appropriate for the safe, efficient and orderly administration of the program and for the maintenance or revocation of licensure under this article.

§ 2999-v. Eligibility and enrollment. 1. To be eligible for enrollment in a PACE organization, an individual must:

(a) Be at least fifty-five years old; and

(b) Meet the state's eligibility criteria for nursing home level of care; and

(c) Reside within the PACE approved service area; and

(d) Be able to be maintained safely in a community-based setting at the time of enrollment with the assistance of the PACE organization; and

(e) Meet any additional program specific eligibility conditions imposed under the PACE program agreement between the PACE organization, the department, and the centers for Medicare and Medicaid services; or

(f) Be otherwise eligible for participation in a PACE demonstration or specialty program authorized by the federal PACE Innovation Act and approved by the centers for Medicare and Medicaid services and the department. Notwithstanding any law or regulation to the contrary, in the event that federal law or regulation permits expanded eligibility or enrollment options, eligibility or enrollment for the applicable PACE organizations may, if approved by the department, conform to such standards as permitted under such federal authority.

2. Enrollment and participation by individuals in PACE organizations shall be voluntary.

§ 2999-w. Included program benefits. Enrollees in all PACE organizations shall be provided a benefit package, regardless of source of payment, that includes:

1. All Medicare-covered items and services;

2. All Medicaid-covered items and services, as specified in the state's Medicaid plan and under section three hundred sixty-four-j of the social services law; and

3. Other such services as determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

§ 2999-x. Reimbursement. The department shall develop and implement, in conformance with applicable federal requirements, a methodology for establishing rates of payment for costs of benefits provided by PACE organizations to its Medicaid eligible enrollees.

§ 4. This act shall take effect immediately; provided, however, that section three of this act shall take effect upon the adoption of rules and regulations by the commissioner of health governing the licensure of PACE organizations as provided under article 29-EE of the public health law as added by section three of this act; provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the adoption of rules and regulations pursuant to such section 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. 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. Subdivision 2 of section 364-j of the social services law is amended by adding a new paragraph (d) to read as follows:

(d) Effective April first, two thousand twenty-two and expiring on the date the commissioner of health publishes on its website a request for proposals in accordance with paragraph (a) of subdivision five of this section, the commissioner of health shall place a moratorium on the processing and approval of applications seeking authority to establish a managed care provider, including applications seeking authorization to expand the scope of eligible enrollee populations. Such moratorium shall not apply to:

(i) applications submitted to the department prior to January first, two thousand twenty-two;

(ii) applications seeking approval to transfer ownership or control of an existing managed care provider;

(iii) applications seeking authorization to expand an existing managed care provider's approved service area;

(iv) applications seeking authorization to form or operate a managed care provider through an entity certified under section four thousand four hundred three-c or four thousand four hundred three-g of the public health law;

(v) applications demonstrating to the commissioner of health's satisfaction that submission of the application for consideration would be appropriate to address a serious concern with care delivery, such as a lack of adequate access to managed care providers in a geographic area or a lack of adequate and appropriate care, language and cultural competence, or special needs services.

§ 2. Subdivision 5 of section 364-j of the social services law, as amended by section 15 of part C of chapter 58 of the laws of 2004, paragraph (a) as amended by section 40 of part A of chapter 56 of the laws of 2013, paragraphs (d), (e) and (f) as amended by section 80 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

5. Managed care programs shall be conducted in accordance with the requirements of this section and, to the extent practicable, encourage the provision of comprehensive medical services, pursuant to this article.

(a) The managed care program **notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic devel-**

opment law, and any other inconsistent provision of law, the commissioner of health shall, through a competitive bid process based on proposals submitted to the department, provide for the selection of qualified managed care providers [~~by the commissioner of health~~] to participate in the managed care program pursuant to a contract with the department, including [~~comprehensive HIV special needs plans and~~] special needs managed care plans in accordance with the provisions of section three hundred sixty-five-m of this title; provided, however, that the commissioner of health may contract directly with comprehensive HIV special needs plans [~~consistent with standards set forth in this section~~] without a competitive bid process, and assure that such providers are accessible taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings, and in sufficient numbers to meet the health care needs of participants, and shall consider the extent to which major public hospitals are included within such providers' networks[~~.~~

~~(b) A proposal~~]; and provided further that:

(i) Proposals submitted by a managed care provider to participate in the managed care program shall:

[~~(i)~~] (A) designate the geographic [~~area~~] areas, as defined by the commissioner of health in the request for proposals, to be served [~~by the provider~~], and estimate the number of eligible participants and actual participants in such designated area;

[~~(ii)~~] (B) include a network of health care providers in sufficient numbers and geographically accessible to service program participants;

[~~(iii)~~] (C) describe the procedures for marketing in the program location, including the designation of other entities which may perform such functions under contract with the organization;

[~~(iv)~~] (D) describe the quality assurance, utilization review and case management mechanisms to be implemented;

[~~(v)~~] (E) demonstrate the applicant's ability to meet the data analysis and reporting requirements of the program;

[~~(vi)~~] (F) demonstrate financial feasibility of the program; and

[~~(vii)~~] (G) include such other information as the commissioner of health may deem appropriate.

(ii) In addition to the criteria described in subparagraph (i) of this paragraph, the commissioner of health shall also consider:

(A) accessibility and geographic distribution of network providers, taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings;

(B) the extent to which major public hospitals are included in the submitted provider network;

(C) demonstrated cultural and language competencies specific to the population of participants;

(D) the corporate organization and status of the bidder as a charitable corporation under the not-for-profit corporation law;

(E) the ability of a bidder to offer plans in multiple regions;

(F) the type and number of products the bidder proposes to operate, including products bid for in accordance with the provisions of subdivision six of section four thousand four hundred three-f of the public health law, and other products determined by the commissioner of health, including but not necessarily limited to those operated under title one-A of article twenty-five of the public health law and section three hundred sixty-nine-gg of this article;

(G) whether the bidder participates in products for integrated care for participants who are dually eligible for medicaid and medicare;

(H) whether the bidder participates in value based payment arrangements as defined by the department, including the delegation of significant financial risk to clinically integrated provider networks;

(I) the bidder's commitment to participation in managed care in the state;

(J) the bidder's commitment to quality improvement;

(K) the bidder's commitment to community reinvestment spending, as shall be defined in the procurement;

(L) for current or previously authorized managed care providers, past performance in meeting managed care contract or federal or state requirements, and if the commissioner issued any statements of findings, statements of deficiency, intermediate sanctions or enforcement actions to a bidder for non-compliance with such requirements, whether the bidder addressed such issues in a timely manner;

(M) such criteria as the commissioner of health shall develop, with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable; and

(N) any other criteria deemed appropriate by the commissioner of health.

(iii) Subparagraphs (i) and (ii) of this paragraph describing proposal content and selection criteria requirements shall not be construed as limiting or requiring the commissioner of health to evaluate such content or criteria on a pass-fail, scale, or other methodological basis; provided however, that the commissioner shall consider all such content and criteria using methods determined by the commissioner of health in their discretion and, as applicable, in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services.

(iv) The department of health shall post on its website:

(A) The request for proposals and a description of the proposed services to be provided pursuant to contracts in accordance with this subdivision;

(B) The criteria on which the department shall determine qualified bidders and evaluate their proposals, including all criteria identified in this subdivision;

(C) The manner by which a proposal may be submitted, which may include submission by electronic means;

(D) The manner by which a managed care provider may continue to participate in the managed care program pending award of managed care providers through a competitive bid process pursuant to this subdivision; and

(E) Upon award, the managed care providers that the commissioner intends to contract with pursuant to this subdivision, provided that the commissioner shall update such list to indicate the final slate of contracted managed care providers.

(v)(A) All responsive submissions that are received from bidders in a timely fashion shall be reviewed by the commissioner of health in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable. The commissioner shall consider comments resulting from the review of proposals and make awards in consultation with such agencies.

(B) The commissioner of health shall make awards under this subdivision for each product, for which proposals were requested, to at least two managed care providers in each geographic region defined by the commissioner in the request for proposals for which at least two managed care providers have submitted a proposal, and shall have discretion to offer more contracts based on need for access; provided, however, that the commissioner of health shall not offer any more than five (5) contracts in any one region.

(C) Managed care providers awarded under this subdivision shall be entitled to enter into a contract with the department for the purpose of participating in the managed care program. Such contracts shall run for a term to be determined by the commissioner, which may be renewed or modified from time to time without a new request for proposals, to ensure consistency with changes in federal and state laws, regulations or policies, including but not limited to the expansion or reduction of medical assistance services available to participants through a managed care provider.

(D) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department of health to terminate awarded contracts for cause, which shall include but not be limited to any violation of the terms of such contracts or violations of state or federal laws and regulations and any loss of necessary state or federal funding.

(E) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the department of health may, in accordance with the provisions of this paragraph, issue new requests for proposals and award new contracts for terms following an existing term of a contract entered into under this paragraph.

(b)(i) Within sixty days of the department of health issuing the request for proposals under paragraph (a) of this subdivision, a managed care provider that was approved to participate in the managed care program prior to the issuance of the request for proposals, shall submit its intention to complete such proposal to the department.

(ii) A managed care provider that: (A) fails to submit its intent timely, (B) indicates within the sixty-days its intent not to complete such a proposal, (C) fails to submit a proposal within the further timeframe specified by the commissioner of health in the request for proposals, or (D) is not awarded the ability to participate in the managed care program under paragraph (a) of this subdivision, shall, upon direction from the commissioner of health, terminate its services and operations in accordance with the contract between the managed care provider and the department of health and shall be additionally required to maintain coverage of participants for such period of time as determined necessary by the commissioner of health to achieve the safe and orderly transfer of participants.

(c) [~~The commissioner of health shall make a determination whether to approve, disapprove or recommend modification of the proposal~~] If necessary to ensure access to sufficient number of managed care providers on a geographic or other basis, including a lack of adequate and appropriate care, language and cultural competence, or special needs services, the commissioner of health may reissue a request for proposals as provided for under paragraph (a) of this subdivision, provided however, that such request may be limited to the geographic or other basis of need that the request for proposals is seeking to address. Any awards

made shall be subject to the requirements of this section, including but not limited to the minimum and maximum number of awards in a region.

(d) [~~Notwithstanding any inconsistent provision of this title and section one hundred sixty-three of the state finance law, the commissioner of health may contract with managed care providers approved under paragraph (b) of this subdivision, without a competitive bid or request for proposal process, to provide coverage for participants pursuant to this title.~~

~~(e) Notwithstanding any inconsistent provision of this title and section one hundred forty-three of the economic development law, no notice in the procurement opportunities newsletter shall be required for contracts awarded by the commissioner of health, to qualified managed care providers pursuant to this section.~~

~~(f)~~] The care and services described in subdivision four of this section will be furnished by a managed care provider pursuant to the provisions of this section when such services are furnished in accordance with an agreement with the department of health, and meet applicable federal law and regulations.

[~~(g)~~] (e) The commissioner of health may delegate some or all of the tasks identified in this section to the local districts.

[~~(h)~~] (f) Any delegation pursuant to paragraph [~~(g)~~] (e) of this subdivision shall be reflected in the contract between a managed care provider and the commissioner of health.

§ 3. Subdivision 4 of section 365-m of the social services law is REPEALED and a new subdivision 4 is added to read as follows:

4. The commissioner of health, jointly with the commissioners of the office of mental health and the office of addiction services and supports, shall select a limited number of special needs managed care plans under section three hundred sixty-four-j of this title, in accordance with subdivision five of such section, capable of managing the behavioral and physical health needs of medical assistance enrollees with significant behavioral health needs.

§ 4. The opening paragraph of subdivision 2 of section 4403-f of the public health law, as amended by section 8 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

An eligible applicant shall submit an application for a certificate of authority to operate a managed long term care plan upon forms prescribed by the commissioner, including any such forms or process as may be required or prescribed by the commissioner in accordance with the competitive bid process under subdivision six of this section. Such eligible applicant shall submit information and documentation to the commissioner which shall include, but not be limited to:

§ 5. Subdivision 3 of section 4403-f of the public health law, as amended by section 41-a of part H of chapter 59 of the laws of 2011, is amended to read as follows:

3. Certificate of authority; approval. (a) The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the commissioner's satisfaction:

[~~(a)~~] (i) that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;

[~~(b)~~] (ii) that it will include an enrollment process which shall ensure that enrollment in the plan is informed. The application shall describe the disenrollment process, which shall provide that an other-

wise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;

[~~(c)~~] (iii) satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;

[~~(d)~~] (iv) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

[~~(e)~~] (v) readiness and capability to maximize reimbursement of and coordinate services reimbursed pursuant to title XVIII of the federal social security act and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

[~~(f)~~] (vi) readiness and capability to arrange and manage covered services and coordinate non-covered services which could include primary, specialty, and acute care services reimbursed pursuant to title XIX of the federal social security act;

[~~(g)~~] (vii) willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law;

[~~(h)~~] (viii) that the contractual arrangements for providers of health and long term care services in the benefit package are sufficient to ensure the availability and accessibility of such services to the proposed enrolled population consistent with guidelines established by the commissioner; with respect to individuals in receipt of such services prior to enrollment, such guidelines shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care. In addition, such guidelines shall require managed long term care plans to offer and cover consumer directed personal assistance services for eligible individuals who elect such services pursuant to section three hundred sixty-five-f of the social services law; and

[~~(i)~~] (ix) that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, the approval of any application for certification as a managed long term care plan under this section for a plan that seeks to cover a population of enrollees eligible for services under title XIX of the federal social security act, shall be subject to and conditioned on selection through the competitive bid process provided under subdivision six of this section.

§ 6. Subdivision 6 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, paragraph (a) as amended by section 4 and paragraphs (d), (e) and (f) as added by section 5 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

6. Approval authority. [~~(a)~~] An applicant shall be issued a certificate of authority as a managed long term care plan upon a determination

by the commissioner that the applicant complies with the operating requirements for a managed long term care plan under this section; provided, however, that any managed long term care plan seeking to provide health and long term care services to a population of enrollees that are eligible under title XIX of the federal social security act shall not receive a certificate of authority, nor be eligible for a contract to provide such services with the department, unless selected through the competitive bid process described in this subdivision. [~~The commissioner shall issue no more than seventy-five certificates of authority to managed long term care plans pursuant to this section. Nothing in this section shall be construed as requiring the department to contract with or to contract for a particular line of business with an entity certified under this section for the provision of services available under title eleven of article five of the social services law.~~

~~(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. Nothing in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.~~

~~(c) For the period beginning April first, two thousand twelve and ending March thirty-first, two thousand fifteen, the majority leader of the senate and the speaker of the assembly may each recommend to the commissioner, in writing, up to four eligible applicants to convert to be approved managed long term care plans. An applicant shall only be approved and issued a certificate of authority if the commissioner determines that the applicant meets the requirements of subdivision three of this section. The majority leader of the senate or the speaker of the assembly may assign their authority to recommend one or more applicants under this section to the commissioner.~~]

(a) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the commissioner of health shall, through a competitive bid process based on proposals submitted to the department, provide for the selection of qualified managed long term care plans to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act pursuant to a contract with the department; provided, however, that:

(i) A proposal submitted by a managed long term care plan shall include information sufficient to allow the commissioner to evaluate the bidder in accordance with the requirements identified in subdivisions two through four of this section.

(ii) In addition to the criteria described in subparagraph (i) of this paragraph, the commissioner shall also consider:

(A) accessibility and geographic distribution of network providers, taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings;

(B) the extent to which major public hospitals are included in the submitted provider network, if applicable;

(C) demonstrated cultural and language competencies specific to the population of participants;

(D) the corporate organization and status of the bidder as a charitable corporation under the not-for-profit corporation law;

(E) the ability of a bidder to offer plans in multiple regions;

(F) the type and number of products the bidder proposes to operate, including products applied for in accordance with the provisions of subdivision five of section three hundred sixty-four-j of the social services law, and other products determined by the commissioner, including but not necessarily limited to those operated under title one-A of article twenty-five of this chapter and section three hundred sixty-nine-gg of the social services law;

(G) whether the bidder participates in products for integrated care for participants who are dually eligible for medicaid and medicare;

(H) whether the bidder participates in value based payment arrangements as defined by the department, including the delegation of significant financial risk to clinically integrated provider networks;

(I) the bidder's commitment to participation in managed care in the state;

(J) the bidder's commitment to quality improvement;

(K) the bidder's commitment to community reinvestment spending, as shall be defined in the procurement;

(L) for current or previously authorized managed care providers, past performance in meeting managed care contract or federal or state requirements, and if the commissioner issued any statements of findings, statements of deficiency, intermediate sanctions or enforcement actions to a bidder for non-compliance with such requirements, whether the bidder addressed such issues in a timely manner;

(M) such criteria as the commissioner shall develop, with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services; and

(N) any other criteria deemed appropriate by the commissioner.

(iii) Subparagraphs (i) and (ii) of this paragraph describing proposal content and selection criteria requirements shall not be construed as limiting or requiring the commissioner to evaluate such content or criteria on a pass-fail, scale, or other particular methodological basis; provided however, that the commissioner must consider all such content and criteria using methods determined by the commissioner in their discretion and, as applicable, in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services.

(iv) The department shall post on its website:

(A) The request for proposals and a description of the proposed services to be provided pursuant to contracts in accordance with this subdivision;

(B) The criteria on which the department shall determine qualified bidders and evaluate their applications, including all criteria identified in this subdivision;

(C) The manner by which a proposal may be submitted, which may include submission by electronic means;

(D) The manner by which a managed long term care plan may continue to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act pending awards to managed long term care plans through a competitive bid process pursuant to this subdivision; and

(E) Upon award, the managed long term care plans that the commissioner intends to contract with pursuant to this subdivision, provided that the commissioner shall update such list to indicate the final slate of contracted managed long term care plans.

(v) (A) All responsive submissions that are received from bidders in a timely fashion shall be reviewed by the commissioner of health in consultation with the commissioners of the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, and the office of children and family services, as applicable. The commissioner shall consider comments resulting from the review of proposals and make awards in consultation with such agencies.

(B) The commissioner shall make awards under this subdivision, for each product for which proposals were requested, to at least two managed long term care plans in each geographic region defined by the commissioner in the request for proposals for which at least two managed long term care plans have submitted a proposal, and shall have discretion to offer more contracts based on need for access; provided, however, that the commissioner shall not offer any more than five (5) contracts in any one region.

(C) Managed long term care plans awarded under this subdivision shall be entitled to enter into a contract with the department for the purpose of providing health and long term care services to enrollees who are eligible under title XIX of the federal social security act. Such contracts shall run for a term to be determined by the commissioner, which may be renewed or modified from time to time without a new request for proposals, to ensure consistency with changes in federal and state laws, regulations or policies, including but not limited to the expansion or reduction of medical assistance services available to participants through a managed long term care plan.

(D) Nothing in this paragraph or other provision of this section shall be construed to limit in any way the ability of the department to terminate awarded contracts for cause, which shall include but not be limited to any violation of the terms of such contracts or violations of state or federal laws and regulations and any loss of necessary state or federal funding.

(E) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, sections one hundred forty-two and one hundred forty-three of the economic development law, and any other inconsistent provision of law, the department may, in accordance with the provisions of this paragraph, issue new requests for proposals and award new contracts for terms following an existing term of a contract entered into under this paragraph.

(b) (i) Within sixty days of the department issuing the request for proposals under paragraph (a) of this subdivision, a managed long term care plan that was approved to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act prior to the issuance of the request for proposals, shall submit its intention to complete such proposal to the department.

(ii) A managed long term care plan that: (A) fails to submit its intent timely, (B) indicates within the sixty days its intent not to complete such a proposal, (C) fails to submit a proposal within the further timeframe specified by the commissioner in the request for proposals, or (D) is not awarded the ability to provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act under paragraph (a) of this subdivision, shall, upon direction from the commissioner, terminate its services and operations in accordance with the contract between the managed long term care plan and the department and shall be additionally required to maintain coverage of enrollees for such period of time as determined neces-

sary by the commissioner to achieve the safe and orderly transfer of enrollees.

(c) Addressing needs for additional managed long term care plans to ensure access and choice for enrollees eligible under title XIX of the federal social security act. If necessary to ensure access to sufficient number of managed long term care plans on a geographic or other basis, including a lack of adequate and appropriate care, language and cultural competence, or special needs services, the commissioner may reissue a request for proposals as provided for under paragraph (a) of this subdivision, provided however that such request may be limited to the geographic or other basis of need that the request for proposals seeks to address. Any awards made shall be subject to the requirements of this section, including but not limited to the minimum and maximum number of awards in a region.

(d) (i) Effective April first, two thousand twenty, and expiring [~~March thirty-first, two thousand twenty-two~~] on the date the commissioner publishes on its website a request for proposals in accordance with subparagraph (iv) of paragraph (a) of the subdivision, the commissioner shall place a moratorium on the processing and approval of applications seeking a certificate of authority as a managed long term care plan pursuant to this section, including applications seeking authorization to expand an existing managed long term care plan's approved service area or scope of eligible enrollee populations. Such moratorium shall not apply to:

(A) applications submitted to the department prior to January first, two thousand twenty;

(B) applications seeking approval to transfer ownership or control of an existing managed long term care plan;

(C) applications demonstrating to the commissioner's satisfaction that submission of the application for consideration would be appropriate to address a serious concern with care delivery, such as a lack of adequate access to managed long term care plans in a geographic area or a lack of adequate and appropriate care, language and cultural competence, or special needs services; and

(D) applications seeking to operate under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or to serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan, based on the need for such plans and the experience of applicants in serving dually eligible individuals as determined by the commissioner in their discretion.

(ii) For the duration of the moratorium, the commissioner shall assess the public need for managed long term care plans that are not integrated with an affiliated Medicare plan, the ability of such plans to provide high quality and cost effective care for their membership, and based on such assessment develop a process and conduct an orderly wind-down and elimination of such plans, which shall coincide with the expiration of the moratorium unless the commissioner determines that a longer wind-down period is needed.

(e) [~~For the duration of the moratorium under paragraph (d) of this subdivision~~] From April first, two thousand twenty, until March thirty-first, two thousand twenty-two, the commissioner shall establish, and enforce by means of a premium withholding equal to three percent of the base rate, an annual cap on total enrollment (enrollment cap) for each managed long term care plan, subject to subparagraphs (ii) and (iii) of

this paragraph, based on a percentage of each plan's reported enrollment as of October first, two thousand twenty.

(i) The specific percentage of each plan's enrollment cap shall be established by the commissioner based on: (A) the ability of individuals eligible for such plans to access health and long term care services, (B) plan quality of care scores, (C) historical plan disenrollment, (D) the projected growth of individuals eligible for such plans in different regions of the state, (E) historical plan enrollment of patients with varying levels of need and acuity, and (F) other factors in the commissioner's discretion to ensure compliance with federal requirements, appropriate access to plan services, and choice by eligible individuals.

(ii) In the event that a plan exceeds its annual enrollment cap, the commissioner is authorized under this paragraph to retain all or a portion of the premium withheld based on the amount over which a plan exceeds its enrollment cap. Penalties assessed pursuant to this subdivision shall be determined by regulation.

(iii) The commissioner may not establish an annual cap on total enrollment under this paragraph for plans' lines of business operating under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or that serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan.

[~~(f) In implementing the provisions of paragraphs (d) and (e) of this subdivision, the commissioner shall, to the extent practicable, consider and select methodologies that seek to maximize continuity of care and minimize disruption to the provider labor workforce, and shall, to the extent practicable and consistent with the ratios set forth herein, continue to support contracts between managed long term care plans and licensed home care services agencies that are based on a commitment to quality and value.~~]

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

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

(vi) **contracts with any national cancer institute-designated cancer center licensed by the department within the health plan's service area that is willing to agree to provide cancer-related inpatient, outpatient and medical services to enrollees in all health plans offering coverage through the Marketplace in such cancer center's service area under the prevailing terms and conditions that the plan requires of other similar providers to be included in the plan's provider network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services; and**

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

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

(w) A managed care provider shall provide or arrange, directly or indirectly, including by referral, for access to and coverage of

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

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

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

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

§ 11. Sections one, two, three, four, five, six and ten of this act shall take effect immediately; sections seven, eight and nine shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all coverage or policies issued or renewed on or after such effective date and shall expire and be deemed repealed five years after such date; provided, however, that the amendments to section 364-j of the social services law made by sections one, two and eight of this act, the amendments to section 4403-f of the public health law made by sections four, five and six of this act and the amendments to paragraph (c) of subdivision 1 of section 369-gg of the social services law made by section nine of this act shall not affect the repeal of such sections or such paragraph and shall be deemed repealed therewith; provided, further, that this act shall not be construed to prohibit managed care providers participating in the managed care program and managed long term care plans approved to

provide health and long term care services to enrollees who are eligible under title XIX of the federal social security act, that were so authorized as of the date this act becomes effective, from continuing operations as authorized until such time as awards are made in accordance with this act and such additional time subject to direction from the commissioner of health to ensure the safe and orderly transfer of participants.

PART Q

Section 1. Section 268-c of the public health law is amended by adding a new subdivision 25 to read as follows:

25. The commissioner is authorized to submit the appropriate waiver applications to the United States secretary of health and human services and/or the department of the treasury to waive any applicable provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148 as amended, or successor provisions, as provided for by 42 U.S.C. 18052, and any other waivers necessary to achieve the purposes of high quality, affordable coverage through NY State of Health, the official health plan marketplace. The commissioner shall implement the state plans of any such waiver in a manner consistent with applicable state and federal laws, as authorized by the secretary of health and human services and/or the secretary of the treasury pursuant to 42 U.S.C. 18052. Copies of such original waiver applications and amendments thereto shall be provided to the chair of the senate finance committee, the chair of the assembly ways and means committee and the chairs of the senate and assembly health committees simultaneously with their submission to the federal government.

§ 2. Paragraph (d) of subdivision 3 of section 369-gg of the social services law, as amended by section 2 of part H of chapter 57 of the laws of 2021, is amended to read as follows:

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

(ii) subject to federal approval and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, has household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this

title if such alien would be ineligible for medical assistance under title eleven of this article due to their immigration status;

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible to receive coverage for health care services pursuant to subparagraph (i) or (ii) of this paragraph is eligible to receive and/or to continue to receive health care services pursuant to this title during the pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this title; or

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

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

§ 3. Paragraph (d) of subdivision 3 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

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

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

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible to receive coverage for health care services pursuant to subparagraph (i) or (ii) of this paragraph is eligible to receive and/or to continue to receive health

care services pursuant to this title during the pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this title; or

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

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

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

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, [~~and~~] (ii) dental and vision services as defined by the commissioner, and (iii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

§ 5. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, and (ii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

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

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the

essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, [~~and~~] (ii) dental and vision services as defined by the commissioner**, and (iii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting**;

§ 7. Paragraph (c) of subdivision 1 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) "Health care services" means **(i)** the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits**, and (ii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting**;

§ 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:

(a) the amendments to paragraph (d) of subdivision 3 of section 369-gg of the social services law made by section two of this act shall be subject to the expiration and reversion of such paragraph pursuant to section 3 of part H of chapter 57 of the laws of 2021 as amended, when upon such date the provisions of section three of this act shall take effect;

(b) section four of this act shall take effect January 1, 2023 and shall expire and be deemed repealed December 31, 2024; 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; and

(c) section six of this act shall take effect January 1, 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 seven of this act shall take effect.

PART R

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

(36) Every policy that provides medical, major medical or similar comprehensive type coverage delivered or issued for delivery in this state shall provide coverage for abortions. Coverage for abortions shall not be subject to copayments, or coinsurance, or annual deductibles, unless the policy is a high deductible health plan, as defined in 26 U.S.C. § 223(c)(2), in which case coverage for abortions may be subject to the plan's annual deductible.

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

(22) (A) Except as provided in subparagraph (B) of this paragraph, every group or blanket policy that provides medical, major medical, or similar comprehensive type coverage delivered or issued for delivery in this state shall provide coverage for abortions. Coverage for abortions shall not be subject to copayments, or coinsurance, or annual deductibles, unless the policy is a high deductible health plan, as defined in 26 U.S.C. § 223(c)(2), in which case coverage for abortions may be subject to the plan's annual deductible.

(B) A group or blanket policy that provides medical, major medical, or similar comprehensive type coverage to a religious employer may exclude coverage for abortions only if the insurer:

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

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

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

(C) For the purpose of this paragraph, "religious employer" means an entity:

(i) for which the inculcation of religious values is the purpose of the entity;

(ii) that primarily employs persons who share the religious tenets of the entity;

(iii) that serves primarily persons who share the religious tenets of the entity; and

(iv) that is a nonprofit organization as described in 26 U.S.C. § 6033(a)(3)(A)(i) or (iii).

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

(ss)(1) Except as provided in paragraph two of this subsection, every individual and group contract that provides medical, major medical or similar comprehensive type coverage delivered or issued for delivery in this state shall provide coverage for abortions. Coverage for abortions shall not be subject to copayments, or coinsurance, or annual deductibles, unless the contract is a high deductible health plan, as defined in 26 U.S.C. § 223(c)(2), in which case coverage for abortions may be subject to the plan's annual deductible.

(2) A group contract that provides medical, major medical, or similar comprehensive type coverage to a religious employer may exclude coverage for abortions only if the corporation:

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

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

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

(3) For the purpose of this subsection, "religious employer" means an entity:

(A) for which the inculcation of religious values is the purpose of the entity;

(B) that primarily employs persons who share the religious tenets of the entity;

(C) that serves primarily persons who share the religious tenets of the entity; and

(D) that is a nonprofit organization as described in 26 U.S.C. § 6033(a)(3)(A)(i) or (iii).

§ 4. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date. Effective immediately, the addition, amendment, or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART S

Section 1. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (jj) to read as follows:

(jj) pre-natal and post-partum care and services for the purpose of improving maternal health outcomes and reduction of maternal mortality, as determined by the commissioner of health, when such services are recommended by a physician or other licensed practitioner of the healing arts, and provided by qualified practitioners, as determined by the commissioner of health; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

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

(3) cooperates with the appropriate social services official or the department in establishing paternity or in establishing, modifying, or

enforcing a support order with respect to his or her child; provided, however, that nothing herein contained shall be construed to require a payment under this title for care or services, the cost of which may be met in whole or in part by a third party; notwithstanding the foregoing, a social services official shall not require such cooperation if the social services official or the department determines that such actions would be detrimental to the best interest of the child, applicant, or recipient, or with respect to pregnant women during pregnancy and during the [~~sixty-day~~] **one year** period beginning on the last day of pregnancy, in accordance with procedures and criteria established by regulations of the department consistent with federal law; and

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

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

§ 4. Paragraph (b) of subdivision 1 of section 366 of the social services law is amended by adding a new subparagraph 8 to read as follows:

(8) Notwithstanding the provisions of subparagraph two of this paragraph, a pregnant individual that is ineligible for federally funded medical assistance solely due to their immigration status is eligible for standard coverage if their MAGI household income does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the secretary of the United States department of health and human services.

§ 5. Section 369-hh of the social services law is REPEALED.

§ 6. 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 two, three, four and five of this act shall take effect January 1, 2023.

PART T

Section 1. Subdivision 1 of section 2308 of the public health law is amended to read as follows:

1. Every physician **or other authorized practitioner** attending pregnant [~~women~~] **patients** in the state shall in the case of every [~~woman~~] **patient** so attended take or cause to be taken a sample of blood of such [~~woman~~] **patient** at the time of first examination, and submit such sample to an approved laboratory for a standard serological test for syphilis. **In addition to testing at the time of first examination, every such physician or other authorized practitioner shall order a syphilis test during**

the third trimester of pregnancy consistent with any guidance and regulations issued by the commissioner.

§ 2. This act shall take effect one year after it shall have become a law. Effective immediately, any rules and regulations or guidance necessary to implement the provisions of this act on its effective date are authorized to be amended, repealed and/or promulgated on or before such date.

PART U

Section 1. Subdivision 7 of section 2510 of the public health law, as amended by chapter 436 of the laws of 2021, is amended to read as follows:

7. "Covered health care services" means: the services of physicians, optometrists, nurses, nurse practitioners, midwives and other related professional personnel which are provided on an outpatient basis, including routine well-child visits; diagnosis and treatment of illness and injury; inpatient health care services; laboratory tests; diagnostic x-rays; prescription and non-prescription drugs, ostomy **and other medical** supplies and durable medical equipment; radiation therapy; chemotherapy; hemodialysis; outpatient blood clotting factor products and other treatments and services furnished in connection with the care of hemophilia and other blood clotting protein deficiencies; emergency room services; **ambulance services;** hospice services; emergency, preventive and routine dental care, including [~~**medically necessary**~~] orthodontia but excluding cosmetic surgery; emergency, preventive and routine vision care, including eyeglasses; speech and hearing services; [~~**and,**~~] inpatient and outpatient mental health, alcohol and substance abuse services**, including children and family treatment and support services, children's home and community based services, assertive community treatment services and residential rehabilitation for youth services; and health-related services provided by voluntary foster care agency health facilities licensed pursuant to article twenty-nine-I of this chapter;** as defined by the commissioner [~~**in consultation with the superintendent**~~]. "Covered health care services" shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that any denial of coverage of such drugs, procedures or supplies shall provide the patient with the means of obtaining additional information concerning both the denial and the means of challenging such denial.

§ 2. Subdivision 9 of section 2510 of the public health law is amended by adding a new paragraph (e) to read as follows:

(e) for periods on or after October first, two thousand twenty-two, amounts as follows:

(i) no payments are required for eligible children whose family household income is less than two hundred twenty-three percent of the non-farm federal poverty level and for eligible children who are American Indians or Alaskan Natives, as defined by the United States department of health and human services, whose family household income is less than two hundred fifty-one percent of the non-farm federal poverty level; and

(ii) fifteen dollars per month for each eligible child whose family household income is between two hundred twenty-three percent and two hundred fifty percent of the non-farm federal poverty level, but no more than forty-five dollars per month per family; and

(iii) thirty dollars per month for each eligible child whose family household income is between two hundred fifty-one percent and three hundred percent of the non-farm federal poverty level, but no more than ninety dollars per month per family; and

(iv) forty-five dollars per month for each eligible child whose family household income is between three hundred one percent and three hundred fifty percent of the non-farm federal poverty level, but no more than one hundred thirty-five dollars per month per family; and

(v) sixty dollars per month for each eligible child whose family household income is between three hundred fifty-one percent and four hundred percent of the non-farm federal poverty level, but no more than one hundred eighty dollars per month per family.

§ 3. Subdivision 8 of section 2511 of the public health law is amended by adding a new paragraph (i) to read as follows:

(i) Notwithstanding any inconsistent provision of this title, articles thirty-two and forty-three of the insurance law and subsection (e) of section eleven hundred twenty of the insurance law:

(i) The commissioner shall, subject to approval of the director of the division of the budget, develop reimbursement methodologies for determining the amount of subsidy payments made to approved organizations for the cost of covered health care services coverage provided pursuant to this title for payments made on and after January first, two thousand twenty-four.

(ii) Effective January first, two thousand twenty-three, the commissioner shall coordinate with the superintendent of financial services for the transition of the subsidy payment rate setting function to the department and, in conjunction with its independent actuary, review reimbursement methodologies developed in accordance with subparagraph (i) of this paragraph. Notwithstanding section one hundred sixty-three of the state finance law, the commissioner may select and contract with the independent actuary selected pursuant to subdivision eighteen of section three hundred sixty-four-j of the social services law, without a competitive bid or request for proposal process. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of reimbursement methodologies, including but not limited to the adequacy of subsidy payment amounts in relation to the population to be served adjusted for case mix, the scope of services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards.

§ 4. Paragraph b of subdivision 7 of section 2511 of the public health law, as amended by chapter 923 of the laws of 1990, is amended to read as follows:

(b) The commissioner, in consultation with the superintendent, shall make a determination whether to approve, disapprove or recommend modification of the proposal. In order for a proposal to be approved by the commissioner, the proposal must also be approved by the superintendent with respect to the provisions of subparagraphs [~~(viii) through~~] (ix) and (xii) of paragraph (a) of this subdivision.

§ 5. This act shall take effect immediately; provided, however, that sections one, three and four of this act shall take effect January 1, 2023 and section two of this act shall take effect April 1, 2022.

PART V

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART W

Section 1. Section 365-g of the social services law, as added by chapter 938 of the laws of 1990, subdivisions 1 and 3 as amended by chapter 165 of the laws of 1991, subdivisions 2 and 4 as amended by section 31 of part C of chapter 58 of the laws of 2008, clause (B) of subparagraph (iii) of paragraph (b) of subdivision 3 as amended by chapter 59 of the laws of 1993, subparagraphs (vi) and (vii) of paragraph (b) of subdivision 3 as amended and subparagraph (viii) as added by section 31-b of part C of chapter 58 of the laws of 2008, subdivision 5 as amended by chapter 41 of the laws of 1992, paragraphs (f) and (g) of subdivision 5 as amended by and paragraphs (h) and (i) as added by section 31-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

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

2. The department may [~~implement~~] review utilization [~~thresholds~~] by provider service type, medical procedure and patient, in consultation with the state department of mental hygiene, other appropriate state agencies, and other stakeholders including provider and consumer representatives. In [~~developing~~] reviewing utilization [~~thresholds~~], the department shall consider historical recipient utilization patterns, patient-specific diagnoses and burdens of illness, and the anticipated recipient needs in order to maintain good health.

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

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

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

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

~~(b) procedures for:~~

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

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

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

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

~~(B) provided for exemptions consistent with department guidelines for approving exemptions, which guidelines must be established by the department in consultation with the department of health and, as appropriate, with the department of mental hygiene, and consistent with the current regulations of the office of mental health governing outpatient treatment.~~

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

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

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

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

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

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

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

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

(a) through a managed care program;

(b) subject to prior approval or prior authorization;

(c) as family planning services;

(d) as methadone maintenance services;

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

(f) for hemodialysis;

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

(h) pursuant to a court order; or

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

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

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

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

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

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

PART X

Section 1. The title heading of title 2-F of article 2 of the public health law, as added by chapter 757 of the laws of 1992 and as relettered by chapter 443 of the laws of 1993, is amended to read as follows:

OFFICE OF [~~MINORITY~~] HEALTH **EQUITY**

§ 2. Section 240 of the public health law, as added by chapter 757 of the laws of 1992 and as renumbered by chapter 443 of the laws of 1993, is amended to read as follows:

§ 240. Definitions. For the purposes of this article:

1. **"Underserved populations" shall mean those who have experienced injustices and disadvantages as a result of their race, ethnicity, sexual orientation, gender identity, gender expression, disability status,**

age, and/or socioeconomic status, among others as determined by the commissioner of health.

2. "[~~Minority~~] Racially and ethnically diverse area" shall mean a county with a non-white population of forty percent or more, or the service area of an agency, corporation, facility or individual providing medical and/or health services whose non-white population is forty percent or more.

[~~2. "Minority health care provider" or "minority provider"~~] 3. "Provider" shall mean any agency, corporation, facility, or individual providing medical and/or health care services to [~~residents of a minority area~~] underserved populations.

[~~3.~~] 4. "Office" shall mean the office of [~~minority~~] health equity, as created pursuant to section two hundred [~~thirty-eight-a~~] forty-one of this [~~article~~] title.

[~~4.~~] 5. "[~~Minority health~~] Health equity council" shall mean that advisory body to the commissioner, created pursuant to the provisions of section two hundred [~~thirty-eight-c~~] forty-three of this [~~article~~] title.

6. "Health disparities" shall mean measurable differences in health status, access to care, and quality of care as determined by race, ethnicity, sexual orientation, gender identity, a preferred language other than English, gender expression, disability status, aging population, and socioeconomic status.

7. "Health equity" shall mean achieving the highest level of health for all people and shall entail focused efforts to address avoidable inequalities by equalizing those conditions for health for those that have experienced injustices, socioeconomic disadvantages, and systemic disadvantages.

8. "Social determinants of health" shall mean life-enhancing resources, such as availability of healthful foods, quality housing, economic opportunity, social relationships, transportation, education, and health care, whose distribution across populations effectively determines the length and quality of life.

§ 3. Section 241 of the public health law, as added by chapter 757 of the laws of 1992 and as renumbered by chapter 443 of the laws of 1993, is amended to read as follows:

§ 241. Office of [~~minority~~] health equity created. There is hereby created an office of [~~minority~~] health equity within the state department of health. Such office shall:

1. Work collaboratively with other state agencies and affected stakeholders, including providers and representatives of underserved populations, in order to set priorities, collect and disseminate data, and align resources within the department and across other state agencies. The office shall also conduct health promotion and educational outreach, as well as develop and implement interventions aimed at achieving health equity among underserved populations by implementing strategies to address the varying complex causes of health disparities, including the economic, physical, and social environments.

2. Integrate and coordinate selected state health care grant and loan programs established specifically for [~~minority~~] promoting health [~~care providers and residents~~] equity in New York state. As part of this function, the office shall develop a coordinated application process for use by [~~minority~~] providers, municipalities and others in seeking funds and/or technical assistance on pertinent [~~minority health care~~] programs and services targeted to address health equity among underserved populations.

[~~2.~~] 3. Apply for grants, and accept gifts from private and public sources for research to improve and enhance [~~minority~~] health [~~care services and facilities~~] equity. The office shall also promote [~~minority~~] health equity research in universities and colleges.

[~~3.~~] 4. Together with the [~~minority~~] health equity council, serve as liaison and advocate for the department on [~~minority~~] health equity matters. This function shall include the provision of staff support to the [~~minority~~] health equity council and the establishment of appropriate program linkages with related federal, state, and local agencies and programs such as the office of [~~minority~~] health equity of the public health service, the agricultural extension service and migrant health services.

[~~4.~~] 5. Assist medical schools and state agencies to develop comprehensive programs to improve [~~minority~~] the diversity of health personnel [~~supply~~] workforce by promoting [~~minority~~] health equity clinical training and curriculum improvement, and disseminating [~~minority~~] health career information to high school and college students.

[~~5.~~] 6. Promote community strategic planning [~~or new or improved health care delivery systems and networks in minority areas~~] to address the complex causes of health disparities, including the social determinants of health and health care delivery systems and networks, in order to improve health equity. Strategic network planning and development may include such considerations as healthful foods, quality housing, economic opportunity, social relationships, transportation, and education, as well as health care systems, including associated personnel, capital facilities, reimbursement, primary care, long-term care, acute care, rehabilitative, preventive, and related services on the health continuum.

[~~6.~~] 7. Review the impact of programs, regulations, and [~~health care reimbursement~~] policies on [~~minority~~] health [~~services delivery and access~~] equity.

§ 4. Section 242 of the public health law, as added by chapter 757 of the laws of 1992 and as renumbered by chapter 443 of the laws of 1993, is amended to read as follows:

§ 242. Preparation and distribution of reports. The department shall submit a biennial report to the governor and the legislature describing the activities of the office and health status of minority areas. The first such report shall be transmitted on or before September first, nineteen hundred ninety-four. Such report shall contain the following information:

1. Activities of the office of [~~minority~~] health equity, expenditures incurred in carrying out such activities, and anticipated activities to be undertaken in the future.

2. Progress in carrying out the functions and duties listed in section two hundred [~~thirty-eight-a~~] forty-one of this [~~article~~] title.

3. An analysis of the health status of [~~minority citizens~~] underserved populations, including those populations within racially and ethnically diverse areas, and the status of [~~minority~~] health delivery systems serving those communities. Such analysis shall be conducted in cooperation with the [~~minority~~] health equity council and other interested agencies.

4. Any recommended improvements to programs and/or regulations that would enhance the cost effectiveness of the office, and programs intended to meet the health and health care needs of [~~minority citizens~~] underserved populations.

§ 5. Section 243 of the public health law, as added by chapter 757 of the laws of 1992 and as renumbered by chapter 443 of the laws of 1993, subdivision 3 as amended by section 55 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

§ 243. [~~Minority health~~] **Health equity** council. 1. Appointment of members. There shall be established in the office of [~~minority~~] health **equity** a [~~minority~~] health **equity** council to consist of the commissioner and fourteen members to be appointed by the governor with the advice and consent of the senate. Membership on the council shall be reflective of the diversity of the state's population including, but not limited to, the various [~~minority~~] **underserved** populations throughout the state.

2. Terms of office; vacancies. a. [~~The~~] **Unless specified otherwise in the bylaws of the health equity council, the** terms of office of members of the [~~minority~~] health **equity** council [~~shall~~] **may** be **up to** six years. The members of the **health equity** council shall continue in office until the expiration of their terms and until their successors are appointed and have qualified. Such appointments shall be made by the governor, with the advice and consent of the senate, within one year following the expiration of such terms.

b. Vacancies shall be filled by appointment by the governor for the unexpired terms within one year of the date upon which such vacancies occur. Any vacancy existing on the effective date of paragraph c of this subdivision shall be filled by appointment within one year of such effective date.

c. In making appointments to the council, the governor shall seek to ensure that membership on the council reflects the diversity of the state's population including, but not limited to the various [~~minority~~] **underserved** populations throughout the state.

3. Meetings. a. The [~~minority~~] health **equity** council shall meet as frequently as its business may require, and at least twice in each year.

b. The governor shall designate one of the members of the public health and health planning council as its chair.

c. A majority of the appointed voting membership of the health equity council shall constitute a quorum.

4. Compensation and expenses. The members of the council shall serve without compensation other than reimbursement of actual and necessary expenses.

5. Powers and duties. The [~~minority~~] health **equity** council shall, at the request of the commissioner, consider any matter relating to the preservation and improvement of [~~minority~~] health **status among the state's underserved populations**, and may advise the commissioner [~~thereon; and it may, from time to time, submit to the commissioner,~~] **on** any recommendations relating to the preservation and improvement of [~~minority~~] health **equity**.

§ 6. This act shall take effect immediately.

PART Y

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

§ 20-c. Certification of marriage; new certificate in case of subsequent change of name or gender. 1. A new marriage certificate shall be issued by the town or city clerk where the marriage license and certificate was issued, upon receipt of proper proof of a change of name or gender designation. Proper proof shall consist of: (a) a judgment, order or decree affirming a change of name or gender designation of either

party to a marriage; (b) an amended birth certificate demonstrating a change of name or gender designation; or (c) such other proof as may be established by the commissioner of health.

2. On every new marriage certificate made pursuant to this section, a notation that it is filed pursuant to this section shall be entered thereon.

3. When a new marriage certificate is made pursuant to this section, the town or city clerk shall substitute such new certificate for the marriage certificate then on file, if any, and shall send the state commissioner of health a digital copy of the new marriage certificate in a format prescribed by the commissioner, with the exception of the city clerk of New York who shall retain their copy. The town or city clerk shall make a copy of the new marriage certificate for the local record and hold the contents of the original marriage certificate confidential along with all supporting documentation, papers and copies pertaining thereto. It shall not be released or otherwise divulged except by order of a court of competent jurisdiction.

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

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

§ 2. This act shall take effect one year after it shall have become a law.

PART Z

Section 1. 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, is amended by adding a new subdivision 9 to read as follows:

(9) This subdivision shall apply only to excess insurance coverage or equivalent excess coverage for physicians or dentists that is eligible to be paid for from funds available in the hospital excess liability pool.

(a) Notwithstanding any law to the contrary, for any policy period beginning on or after July 1, 2021, excess coverage shall be purchased by a physician or dentist directly from a provider of excess insurance coverage or equivalent excess coverage. At the conclusion of the policy period 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, reimburse fifty percent of the premium to the physician or dentist, and the remaining fifty percent shall be paid one year thereafter. If the funds available in the hospital excess liability pool are insufficient to meet the percent of the costs of the excess coverage, the provisions of subdivision 8 of this section shall apply.

(b) No provider of excess insurance coverage or equivalent excess coverage shall issue excess coverage to which this subdivision applies to any physician or dentist unless that physician or dentist meets the

eligibility requirements for such coverage set forth in this section. The superintendent of financial services and the commissioner of health or their designee shall not make any payment under this subdivision to a physician or dentist who does not meet the eligibility requirements for participation in the hospital excess liability pool program set forth in this section.

(c) The superintendent of financial services in consultation with the commissioner of health may promulgate regulations giving effect to the provisions of this subdivision.

§ 2. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

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

and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [~~and~~] between July 1, 2021 and June 30, 2022**, and between July 1, 2022 and June 30, 2023** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 3. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

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

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

June 30, 2023 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage 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, [~~and~~] to the period July 1, 2021 to June 30, 2022**, and to the period July 1, 2022 to June 30, 2023**.

§ 4. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part K of chapter 57 of the laws of 2021, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July

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

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022**, or covering the period July 1, 2022 to June 30, 2023** shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period deter-

mined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

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

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the peri-

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

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

ing the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018, and covering the period July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to June 30, 2020, and covering the period July 1, 2020 to June 30, 2021, and covering the period July 1, 2021 to June 30, 2022**, and covering the period July 1, 2022 to June 30, 2023** for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 5. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 4 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [~~2022~~] **2023**; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [~~2022~~] **2023**, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [~~2022~~] **2023** policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to

remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 6. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part K of chapter 57 of the laws of 2021, are amended to read as follows:

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

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liabil-

ity pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022**, or July 1, 2022 to June 30, 2023** as applicable.

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

§ 7. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

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

or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [~~twenty-one~~] twenty-two and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [~~twenty-one~~] twenty-two.

§ 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.

PART AA

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

SUBPART A

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

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

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

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

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

(1) an insured for services rendered by a non-participating [~~physician~~] **provider** at a participating hospital or ambulatory surgical center, where a participating [~~physician~~] **provider** is unavailable or a non-participating [~~physician~~] **provider** renders services without the insured's knowledge, or unforeseen medical services arise at the time

the health care services are rendered; provided, however, that a surprise bill shall not mean a bill received for health care services when a participating [~~physician~~] **provider** is available and the insured has elected to obtain services from a non-participating [~~physician~~] **provider**;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Emergency services for an insured. (1) When a health care plan receives a bill for emergency services from a non-participating [~~physician or hospital~~] **provider**, including a bill for inpatient services which follow an emergency room visit, the health care plan shall pay an amount that it determines is reasonable for the emergency services, including inpatient services which follow an emergency room visit,

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

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

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

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

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

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

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

§ 606. Hold harmless [~~and assignment of benefits~~] for insureds **from bills for emergency services and surprise bills**. (a) [~~When an insured assigns benefits for a surprise bill in writing to a non-participating~~

~~physician that knows the insured is insured under a health care plan, the~~] A non-participating [~~physician~~] provider shall not bill [~~the~~] an insured for a surprise bill except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating [~~physician~~] provider.

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

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

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

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

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

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

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

(6) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the non-participating [~~physician's~~] provider's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating [~~physician's~~] provider's fee, that a settlement between the health care plan and non-participating [~~physician~~] provider is reasonably likely, or that both the health care plan's payment and the non-participating [~~physician's~~] provider's fee represent

unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating [~~physician~~] **provider** may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty **business** day period for dispute resolution.

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

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

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

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

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

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

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

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

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

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

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

§ 12. This act shall take effect immediately.

SUBPART B

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

(1) If the superintendent finds after notice and hearing that any authorized insurer, representative of the insurer, licensed insurance agent, licensed insurance broker, licensed adjuster, or any other person or entity licensed, certified, registered, or authorized pursuant to this chapter, has [~~wilfully~~] **willfully** violated the provisions of this chapter or any regulation promulgated thereunder **or with respect to accident and health insurance, any provision of federal law or regulation**, then the superintendent may order the person or entity to pay to the people of this state a penalty in a sum not exceeding one thousand dollars for each offense.

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

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, [~~and~~] telephone number**, and digital contact information** of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of [~~alcoholism~~] **addiction services** and [~~substance abuse services~~] **supports**, and any restrictions regarding the availability of the individual provider's services; and (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

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

(m) A contract between an insurer and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider

directory information of the health care provider, and at any other time, including upon the insurer's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

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

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

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, [~~and~~] telephone number, and digital contact information of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports, and any restrictions regarding the availability of the individual provider's services; (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or termination of a provider from the corporation's network or a change in a physician's hospital affiliation;

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

(n) A contract between a corporation and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the corporation. A health care provider shall submit such provider directory information to a corporation, at a minimum, when a provider begins or terminates a network agreement with a corporation, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the corporation's request, as the health care provider determines to be appropriate. For purposes of this subsection,

"provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

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

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

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

12. A contract between a health care plan and a health care provider shall include a provision that states that the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the commissioner in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the enrollee is provided with inaccurate network status information by the health care plan in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provid-

er. Nothing in this subdivision shall prohibit a health care provider from requiring in the terms of a contract with a health care plan that the health care plan remove, at the time of termination of such contract, the provider from the health care plan's provider directory or that the health care plan bear financial responsibility for providing inaccurate network status information to an enrollee.

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

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

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

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

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

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

~~entered the second trimester of pregnancy~~] **is pregnant** at the time of the provider's disaffiliation, [~~for a transitional period that includes~~] the [~~provision of~~] **duration of the pregnancy and** post-partum care directly related to the delivery.

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

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

(e) (1) If an enrollee's health care provider leaves the health maintenance organization's network of providers for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph a of subdivision two of section forty-four hundred six-d of this chapter, the health maintenance organization shall **provide written notice to the enrollee of the provider's disaffiliation and** permit the enrollee to continue an ongoing course of treatment with the enrollee's current health care provider during a transitional period of**:** (i) [~~up to~~] ninety days from the **later of the** date of **the** notice to the enrollee of the provider's disaffiliation from the organization's network **or the effective date of the provider's disaffiliation from the organization's network**; or (ii) if the enrollee [~~has entered the second trimester of pregnancy~~] **is pregnant** at the time of the provider's disaffiliation, [~~for a transitional period that includes~~] the [~~provision of~~] **duration of the pregnancy and** post-partum care directly related to the delivery.

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

§ 11. This act shall take effect immediately.

SUBPART C

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

(e) An insurer that issues a comprehensive policy that uses a network of providers and is not a managed care health insurance contract, as

defined in subsection (c) of section four thousand eight hundred one of this chapter, shall establish and maintain procedures for health care professional applications and terminations consistent with the requirements of section four thousand eight hundred three of this chapter and procedures for health care facility applications consistent with section four thousand eight hundred six of this chapter.

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

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

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

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

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

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

§ 4406-h. Health care facility applications. 1. A health care plan shall, upon request, make available and disclose to facilities written application procedures and minimum qualification requirements that a facility must meet in order to be considered by the health care plan for participation in the in-network benefits portion of the health care plan's network. The health care plan shall consult with appropriately qualified facilities in developing its qualification requirements. A

health care plan shall complete review of the facility's application to participate in the in-network portion of the health care plan's network and shall, within sixty days of receiving a facility's completed application to participate in the health care plan's network, notify the facility as to: (a) whether the facility is credentialed; or (b) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, a health care plan shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

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

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

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

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

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

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

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or subpart of this act shall be adjudged by any court of

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

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

PART BB

Section 1. Paragraph (b) of subdivision 3 of section 273 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. [~~If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that~~] **The program will consider the additional information and the justification presented to determine whether** the use of a prescription drug that is not on the preferred drug list is warranted, **and** the [~~prescriber's~~] **program's** determination shall be final.

§ 2. Subdivisions 25 and 25-a of section 364-j of the social services law are REPEALED.

§ 3. This act shall take effect June 1, 2022.

PART CC

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

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

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

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

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

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

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

(c) section fifty of this act shall take effect immediately [~~and shall expire nine years after it becomes law~~];

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

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, and for the state fiscal year beginning April 1, 2016 through March 31, 2019, and for the state fiscal year beginning April 1, 2019 through March 31, 2022**, and for the state fiscal year beginning April 1, 2022 through March 31, 2025**, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled

to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

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

§ 5. This act shall take effect on the one hundred twentieth day after it shall have become a law[~~, provided, however, that the provisions of sections two, three, and four of this act shall expire and be deemed repealed July 1, 2022; 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~~]. **Effective** immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

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

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

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

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

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

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

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

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

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

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

§ 3. This act shall take effect on the same date and in the same manner as a chapter of the laws of 2019, amending the public health law relating to establishing the rare disease advisory council, as proposed in legislative bills numbers S. 4497 and A. 5762; provided, however, that the provisions of section two of this act shall expire and be deemed repealed [~~three~~] four years after such effective date.

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

§ 5. A report of the findings and recommendations of the task force and any proposed legislation necessary to implement such findings shall be filed with the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate, and the

minority leader of the assembly on or before November first, two thousand [~~twenty-one~~] twenty-two.

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

§ 12. 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 the amendments to section 2 of chapter 74 of the laws of 2020 made by section ten of this section and the amendments to section 5 of chapter 414 of the laws of 2018 made by section eleven of this act, shall not affect the expiration of such section and be deemed to expire therewith.

PART DD

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

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

3. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 5.4 percent cost of living adjustment (COLA) established herein shall be inclusive of all other cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2022. Except for the 5.4 percent cost of living adjustment (COLA) established herein, for the period commencing on April 1, 2022 and ending March 31, 2023 the commissioners shall not apply any other new cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other cost of living type increases, inflation factors, or trend factors" as defined in this subdivision shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic Public Health Emergency.

4. Eligible programs and services. (i) Programs and services funded, licensed, or certified by the office of mental health (OMH) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: office of mental health licensed outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of the office of mental health regulations including clinic, continuing day treatment, day treatment, intensive outpatient programs and partial

hospitalization; outreach; crisis residence; crisis stabilization, crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric emergency program services; crisis intervention; home based crisis intervention; family care; supported single room occupancy; supported housing; supported housing community services; treatment congregate; supported congregate; community residence - children and youth; treatment/apartment; supported apartment; community residence single room occupancy; on-site rehabilitation; employment programs; recreation; respite care; transportation; psychosocial club; assertive community treatment; case management; care coordination, including health home plus services; local government unit administration; monitoring and evaluation; children and youth vocational services; single point of access; school-based mental health program; family support children and youth; advocacy/support services; drop in centers; recovery centers; transition management services; bridger; home and community based waiver services; behavioral health waiver services authorized pursuant to the section 1115 MRT waiver; self-help programs; consumer service dollars; conference of local mental hygiene directors; multicultural initiative; ongoing integrated supported employment services; supported education; mentally ill/chemical abuse (MICA) network; personalized recovery oriented services; children and family treatment and support services; residential treatment facilities operating pursuant to part 584 of title 14-NYCRR; geriatric demonstration programs; community-based mental health family treatment and support; coordinated children's service initiative; homeless services; and promises zone.

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

(iii) Programs and services funded, licensed, or certified by the office of addiction services and supports (OASAS) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: medically supervised withdrawal services - residential; medically supervised withdrawal services - outpatient; medically managed detoxification; medically monitored withdrawal; inpatient rehabilitation services; outpatient opioid treatment; residential opioid treatment; KEEP units outpatient; residential opioid treatment to abstinence; problem gambling treatment; medically supervised outpatient; outpatient rehabilitation; specialized services substance abuse programs; home and community based waiver services pursuant to subdivision 9 of section 366 of the social services law; children and family

treatment and support services; continuum of care rental assistance case management; NY/NY III post-treatment housing; NY/NY III housing for persons at risk for homelessness; permanent supported housing; youth clubhouse; recovery community centers; recovery community organizing initiative; residential rehabilitation services for youth (RRSY); intensive residential; community residential; supportive living; residential services; job placement initiative; case management; family support navigator; local government unit administration; peer engagement; vocational rehabilitation; support services; HIV early intervention services; dual diagnosis coordinator; problem gambling resource centers; problem gambling prevention; prevention resource centers; primary prevention services; other prevention services; and community services.

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

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

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

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

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

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

PART EE

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

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

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

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

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

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

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

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

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

(6) "Mobile crisis teams" means a team licensed, certified, or authorized by the office of mental health and the office of addiction services and supports to provide community-based mental health or substance use disorder interventions for individuals who are experiencing a mental health or substance use disorder crisis.

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

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

(c) The commissioner of the office of mental health, in conjunction with the commissioner of the office of addiction services and supports, shall, on or before July sixteenth, two thousand twenty-two, designate a crisis hotline center or centers to provide or arrange for crisis intervention services to individuals accessing the 9-8-8 suicide prevention

and behavioral health crisis hotline from anywhere within the state twenty-four hours a day, seven days a week. Each 9-8-8 crisis hotline center shall do all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) The number of mobile crisis teams dispatched.

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

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

§ 3. This act shall take effect immediately.

PART FF

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

5. Pursuant to appropriations within the offices of mental health or addiction services and supports, the department of health shall reinvest [~~funds allocated for behavioral health services, which are general fund savings directly related to~~] savings realized through the transition of populations covered by this section from the applicable Medicaid fee-for-service system to a managed care model, including savings [~~resulting from the reduction of inpatient and outpatient behavioral health services provided under the Medicaid programs licensed or certified pursuant to article thirty-one or thirty-two of the mental hygiene law, or programs that are licensed pursuant to both article thirty-one of the mental hygiene law and article twenty-eight of the public health law, or certified under both article thirty-two of the mental hygiene law and article twenty-eight of the public health law~~] realized through the recovery of premiums from managed care providers which represent a reduction of spending on qualifying behavioral health services against established premium targets for behavioral health services and the medical loss ratio applicable to special needs managed care plans, for the purpose of increasing investment in community based behavioral health services, including residential services certified by the office of [~~alcoholism and substance abuse~~] addiction services and supports. The methodologies used to calculate the savings shall be developed by the commissioner of health and the director of the budget in consultation with the commissioners of the office of mental health and the office of [~~alcoholism and substance abuse~~] addiction services and supports. In no event shall the full annual value of the [~~community based behavioral health service~~] reinvestment [~~savings attributable to~~

~~the transition to managed care~~] pursuant to this subdivision exceed the [~~twelve month value of the department of health general fund reductions resulting from such transition~~] value of the premiums recovered from managed care providers which represent a reduction of spending on qualifying behavioral health services. Within any fiscal year where appropriation increases are recommended for reinvestment, insofar as managed care transition savings do not occur as estimated, [~~and general fund savings do not result,~~] then spending for such reinvestment may be reduced in the next year's annual budget itemization. [~~The commissioner of health shall promulgate regulations, and prior to October first, two thousand fifteen, may promulgate emergency regulations as required to distribute funds pursuant to this subdivision; provided, however, that any emergency regulations promulgated pursuant to this section shall expire no later than December thirty-first, two thousand fifteen.~~] The commissioner shall include [~~detailed descriptions of the methodology used to calculate savings~~] information regarding the funds available for reinvestment[~~, the results of applying such methodologies, the details regarding implementation of such reinvestment~~] pursuant to this section[~~, and any regulations promulgated under this subdivision,~~] in the annual report required under section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen.

§ 2. This act shall take effect immediately.

PART GG

Section 1. Section 7 of part H of chapter 57 of the laws of 2019, amending the public health law relating to waiver of certain regulations, as amended by section 7 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019, provided, however, that section two of this act shall expire on April 1, [~~2022~~] 2025.

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

PART HH

Section 1. Section 3309 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. Any pharmacy registered by the New York state department of education and the federal Drug Enforcement Administration (DEA) or its successor agency that maintains a stock of and directly dispenses controlled substance medications pursuant to prescriptions for humans in the state of New York, shall maintain a minimum stock of a thirty day supply of both an opioid antagonist medication and separately an opioid partial agonist medication for the treatment of an opioid use disorder, to the extent permitted pursuant to federal wholesaler threshold limits. For purposes of this subdivision, a thirty day supply of opioid partial agonist medication shall mean any combination of dosages sufficient to fill a prescription of sixteen milligrams per day for a period of thirty days. Where the food and drug administration has defined and approved one or more therapeutic and pharmaceutical equivalents of these medications a pharmacy is not required to maintain a stock of all such versions, so long as at least one version of an opioid antagonist and one version of an opioid partial agonist medication for the treatment of

an opioid use disorder is available to dispense. Where federal and state laws and regulations permit dispensing of opioid full agonist medication for the treatment of an opioid use disorder, such pharmacy may also maintain a stock of opioid full agonist medication consistent with this subdivision.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law.

PART II

Section 1. Paragraph 38 of section 1.03 of the mental hygiene law, as amended by chapter 281 of the laws of 2019, is amended to read as follows:

38. "Residential services facility" or "[~~Alcoholism community~~] Community residence for addiction" means any facility licensed or operated pursuant to article thirty-two of this chapter which provides residential services for the treatment of an addiction disorder and a homelike environment, including room, board and responsible supervision as part of an overall service delivery system.

§ 2. Paragraph 1 of subdivision (a) of section 32.05 of the mental hygiene law, as added by chapter 558 of the laws of 1999, is amended to read as follows:

1. operation of a residential program, including a community residence for the care, custody, or treatment of persons suffering from [~~chemical abuse or dependence~~] an addictive disorder; provided, however, that giving domestic care and comfort to a person in the home shall not constitute such an operation; provided further that the certification of a recovery residence, developed and administered by the commissioner directly or pursuant to a contract with a designated entity, shall have the following structure and meaning for purposes of this section:

(i)(A) "Recovery residence" means a shared living environment free from alcohol and illicit drug use which utilizes peer supports and connection to services to promote sustained recovery from substance use disorder.

(B) "Certified recovery residence" means a recovery residence which complies with standards for the operation of a certified recovery residence which are issued by the office.

(ii) The commissioner shall regulate and assure the consistent high quality of certified recovery residences for individuals in recovery from a substance use disorder. The commissioner, directly or pursuant to contract with a designated entity, shall implement standards for the operation of a certified recovery residence, a voluntary certification process, and conduct ongoing monitoring of recovery residences.

(iii) The commissioner shall maintain on the office website a list of certified recovery residences.

§ 3. Section 41.52 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

§ 41.52 Community residential services for [~~alcoholism~~] addiction.

(a) The commissioner of [~~alcoholism and substance abuse services~~] addiction services and supports is authorized, within appropriations made therefor, to establish a continuum of community residential services for [~~alcoholism~~] addictive disorder services.

(b) The commissioner shall establish standards for the operation and funding of community residential services, including but not limited to:

(1) criteria for admission to and continued residence in each type of community residence;

(2) periodic evaluation of services provided by community residences;
(3) staffing patterns for each type of community residence; and
(4) guidelines for determining state aid to community residences, as described in [~~subdivision (c) of this section~~] article twenty-five of this chapter.
(c) Within amounts available therefor and subject to regulations established by the commissioner and notwithstanding any other provisions of this article, the commissioner may provide state aid to local governments and to voluntary agencies in an amount up to one hundred percent of net operating costs of community residences for alcoholism services. The commissioner shall establish guidelines for determining the amount of state aid provided pursuant to this section. The guidelines shall be designed to enable the effective and efficient operation of such residences and shall include, but need not be limited to, standards for determining anticipated revenue, for retention and use of income exceeding the anticipated amount and for determining reasonable levels of uncollectible income. Such state aid to voluntary agencies shall not be granted unless the proposed community residence is consistent with the relevant local services plan adopted pursuant to section 41.18 of this article.
§ 4. This act shall take effect immediately.

PART JJ

Section 1. The section heading and subdivisions (a) and (d) of section 19.25 of the mental hygiene law, as added by chapter 223 of the laws of 1992, are amended to read as follows:
[~~Alcohol~~] Substance use awareness program.
(a) The office shall establish [~~an alcohol~~] a substance use awareness program within the office which shall focus upon, but not be limited to, the health effects and social costs of [~~alcoholism and alcohol abuse~~] alcohol and cannabis use.
(d) A certificate of completion shall be sent to the court by the [~~office~~] program upon completion of the program by all participants.
§ 2. This act shall take effect immediately.

PART KK

Section 1. Section 9 of section 1 of chapter 359 of the laws of 1968, constituting the facilities development corporation act is amended by adding a new subdivision 7 to read as follows:
7. Expedited process for mental hygiene facilities dedicated for the treatment of addiction. To more swiftly combat addiction issues and consistent with the policies of the state of New York as expressed in section 19.01 of the mental hygiene law, the provisions of this subdivision shall apply to mental hygiene facilities created, or to be created, to offer treatment programs, rehabilitation services, and related and attendant services, for addiction that are licensed, certified or otherwise authorized by the office of addiction services and supports.
a. Notwithstanding any other provision of law, the corporation shall have the authority to:
(i) acquire by lease, purchase, condemnation, gift or otherwise any real property it deems necessary or convenient for use as a mental hygiene facility dedicated to providing addiction programs, rehabilitation services, and related and attendant services; and such lease,

purchase or acquisition shall be in the name of the state, acting by and through the corporation or the dormitory authority, and on behalf of the office of addiction services and supports; and

(ii) design, construct, reconstruct, rehabilitate and improve such mental hygiene facilities on behalf of the office of addiction services and supports, or cause such facilities to be designed, constructed, reconstructed, rehabilitated and improved; and

(iii) in connection with such design, construction, reconstruction, rehabilitation and improvement, to install or cause to be installed water, sewer, gas, electrical, telephone, heating, air conditioning and other utility services, including appropriate connections; and

(iv) make such mental hygiene facility available under lease, sublease, license or permit to a voluntary agency upon such terms and conditions as determined by the office of addiction services and supports; or, notwithstanding the provisions of the public lands law or any other general or special law to the contrary, to convey the right, title and interest of the people of the state of New York in and to such facility and the land appurtenant thereto to such voluntary agency to operate as a mental hygiene facility upon such terms and conditions and for such consideration, if any, as shall be provided in an agreement among the office of addiction services and supports, the corporation and such voluntary agency subject to the attorney general passing upon the form and sufficiency of any deed of conveyance and any lease of real property authorized to be given under this subdivision, which shall only be effective once the deed, lease, sublease or agreement shall have been so approved. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and section one hundred forty-two of the economic development law, or any other inconsistent provision of law, such voluntary agency may be selected by the office of addiction services and supports, without a competitive bid or request for proposal process.

b. All contracts which are to be awarded pursuant to this subdivision shall be publicly advertised pursuant to article four-C of the economic development law.

§ 2. This act shall take effect immediately.

PART LL

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

§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 36, 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of the office of

mental health, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports**, or the office of mental health for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~1~~] **18** of part [~~P~~] **E** of chapter 57 of the laws of [~~2017~~] **2019** through March 31, [~~2023~~] **2027** for patients in the city of New York, for all rate periods on and after the effective date of section [~~1~~] **18** of part [~~P~~] **E** of chapter 57 of the laws of [~~2017~~] **2019** through March 31, [~~2023~~] **2027** for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through March 31, [~~2023~~] **2027** for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral

health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

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

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

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and [~~alcoholism and substance abuse~~] **addiction** services **and supports** are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article **36,** 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of [~~alcoholism and substance abuse~~] **addiction** services **and supports**, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by

the department of health or by the office of mental health or office of [~~alcoholism and substance abuse~~] addiction services and supports for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and [~~alcoholism and substance abuse~~] addiction services and supports, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~2~~] 19 of part [~~P~~] E of chapter 57 of the laws of [~~2017~~] 2019 through March 31, [~~2023~~] 2027 for patients in the city of New York, for all rate periods on and after the effective date of section [~~2~~] 19 of part [~~P~~] E of chapter 57 of the laws of [~~2017~~] 2019 through March 31, [~~2023~~] 2027 for patients outside the city of New York, and for all rate periods on and after the effective date of section [~~2~~] 19 of part [~~P~~] E of chapter 57 of the laws of [~~2017~~] 2019 through March 31, [~~2023~~] 2027 for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioners of mental health and [~~alcoholism and substance abuse~~] addiction services and supports, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

b. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers

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

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

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

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

PART MM

Section 1. Section 18 of chapter 408 of the laws of 1999, constituting Kendra's law, as amended by chapter 67 of the laws of 2017, is amended to read as follows:

§ 18. This act shall take effect immediately, provided that section fifteen of this act shall take effect April 1, 2000, provided, further, that subdivision (e) of section 9.60 of the mental hygiene law as added by section six of this act shall be effective 90 days after this act shall become law; and that this act shall expire and be deemed repealed June 30, [~~2022~~] **2027**.

§ 2. Paragraph 4 of subdivision (c) and paragraph 2 of subdivision (h) of section 9.60 of the mental hygiene law, as amended by chapter 158 of the laws of 2005, are amended and a new subdivision (s) is added to read as follows:

(4) has a history of lack of compliance with treatment for mental illness that has:

(i) **except as otherwise provided in subparagraph (iii) of this paragraph,** prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or

(ii) **except as otherwise provided in subparagraph (iii) of this paragraph,** prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated; [~~and~~] **or**

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph, resulted in the issuance of a court order for assisted outpatient treatment which has expired within the last six months, and since the expiration of the order, the person has experienced a substantial increase in symptoms of mental illness.

(2) The court shall not order assisted outpatient treatment unless an examining physician, who recommends assisted outpatient treatment and has personally examined the subject of the petition no more than ten days before the filing of the petition, testifies in person **or by videoconference** at the hearing. Such physician shall state the facts and clinical determinations which support the allegation that the subject of the petition meets each of the criteria for assisted outpatient treatment.

(s) A director of community services or his or her designee may require a provider of services operated or licensed by the office of mental health to provide information, including but not limited to clinical records and other information concerning persons receiving assisted outpatient treatment pursuant to an active assisted outpatient treatment order, that is deemed necessary by such director or designee to appropriately discharge their duties pursuant to section 9.47 of this article, and where such provider is required to disclose such information pursuant to paragraph twelve of subdivision (c) of section 33.13 of this chapter.

§ 3. This act shall take effect immediately, provided, however that the amendments to section 9.60 of the mental hygiene law made by section two of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART NN

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

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

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

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

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

PART OO

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

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

§ 2. This act shall take effect immediately.

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

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