STATE OF NEW YORK

8007--B

IN SENATE

January 19, 2022

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

AN ACT to 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); intentionally omitted (Part C); to amend the social services law, in relation to establishing 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 seventy-five 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); intentionally omitted (Part G); to repeal sections 91 and 92 of part H of chapter 59 of the laws of 2011 relating to the year to year rate of growth of Department of Health state funds and Medicaid funding, relating to the state Medicaid spending cap and related processes (Part H); relating to provide a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates (Part I); to amend the public health law, in relation to extending the statutory requirement to reweight and rebase acute hospital rates (Part J); to amend the public health law, in relation to the creation of a new statewide health care facility transformation program (Part K); 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

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

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thereto (Part N); to amend the social services law and the public health law, in relation to providing increased rates for private duty nursing services that are provided to medically fragile adults (Subpart A); to amend the public health law, in relation to establishing a state-level program of all-inclusive care for the elderly; to amend the social services law, in relation to making technical corrections to such law; and repealing certain provisions of the social services law relating thereto (Subpart B); to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws, relating to general hospital inpatient reimbursement for annual rates, in relation to supplemental Medicaid managed care payments (Subpart C) (Part O); to amend the public health law and the social services law, in relation to 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 providing for the repeal of certain provisions upon expiration thereof (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 that provision be made for pregnancy termination procedures in every individual or group policy or contract which provides coverage or indemnity for hospital, surgical or medical care and which offers maternity care coverage (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); intentionally omitted (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, in relation to the delivery of health care services via telehealth and modifying the definition of telehealth provider (Part V); intentionally omitted (Part W); intentionally omitted (Part X); to amend the domestic relations law, in relation to marriage certificates (Part Y); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending the 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); intentionally omitted (Part AA); intentionally omitted (Part BB); 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; (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); intentionally omitted (Part JJ); intentionally omitted (Part KK); to amend chapter 56 of the laws of 2013 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and referencing the office of addiction services and supports; to amend part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services referencing the office of addiction services and supports and in relation to the effectiveness thereof (Part LL); to amend Kendra's law, in relation to extending the expiration thereof (Part MM); to amend the mental hygiene law, in relation to rental and mortgage payments for the mentally ill (Part NN); intentionally omitted (Part OO); to amend the social services law and the public health law, in relation to protecting access to pharmacy services (Part PP); to amend the social services law, in relation to removing certain restrictions on access to home care services; and to repeal certain provisions of such law relating thereto (Part QQ); to amend the public health law, the state finance law and 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 fair pay for home care aides (Part RR); to amend the public health law, in relation to enacting the quality incentive vital access provider program act (Part SS); relating to exemptions from certain provisions of the state finance law and the economic development law (Part TT); to amend the mental hygiene law, in relation to funding for services of the office of addiction services and supports (Part UU); to amend the mental hygiene law, in relation to creating the office of addiction and mental health services (Part VV); to amend the mental hygiene law, the state finance law and the general municipal law, in relation to establishing a state crisis intervention demonstration program and a crisis intervention team training fund (Part WW); and to direct the department of health to conduct a statewide study on the support and administration needs of the consumer-directed personal care program (Part XX)

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

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

PART A

Section 1. 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 and licensed practical nurses licensed to practice pursuant to title eight 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 periods 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 Exam-

ination (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.

§ 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 informa-

tion 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

Intentionally Omitted

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 two thousand twenty-three 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 and other workers that provide hands on health or care services to individuals, or that provide services that are integral to such care on-site in patient and residential care settings, including, but not limited to, custodians, house-

keeping, security, and food service workers, 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 twenty-five 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 the 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, pharmacies registered under section six thousand eight hundred eight of the education law, school based health centers, a health district as defined in section two of the public health law, or a municipal corporation;

(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.

(c) Notwithstanding the definition of employer in paragraph (b) of this subdivision, and without regard to the availability of federal financial participation, "employer" shall also include an institution of higher education, a public or nonpublic school, a charter school, an approved preschool program for students with disabilities, a school district or boards of cooperative educational services, programs funded by the office of mental health, programs funded by the office of addiction services and supports, programs funded by the office for people with developmental disabilities, programs funded by the office for the aging, a health district as defined in section two of the public health law, or a municipal corporation, where such program or entity employs at least one employee. Such employers shall be required to enroll in the system designated by the commissioner, or relevant agency commissioners, in consultation with the director of the budget, for the purpose of claiming bonus payments under this section. Such system or process for claiming bonus payments may be different from the system and process used under subdivision three of this section.

(d) "Vesting period" shall mean a series of six-month periods between the dates of October first, two thousand twenty-one and March thirty-first, two thousand twenty-four for which employees that are continuously employed by an employer during such six-month periods, in accordance with a schedule issued by the commissioner or relevant agency commissioner as applicable, may become eligible for a bonus pursuant to subdivision four of this section.

(e) "Base salary" shall mean, for the purposes of this section, the employee's gross wages with the employer during the vesting period, excluding any bonuses or overtime pay.

(f) "Municipal corporation" means a county outside of a city with a population of one million or more, a city, including a city with a population of one million or more, a town, a village, or a school district.

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.

(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) Upon issuance of a vesting schedule by the commissioner, or relevant agency commissioner as applicable, employers shall be required to pay bonuses to employees pursuant to such schedule based on the number of hours worked during the vesting period. 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 thirty-five 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 thirty-five hours per week over the course of a vesting period would receive a one thousand five hundred dollar bonus for such vesting period;

(iv) full-time employees who are exempt from overtime compensation as established in the labor commissioner's minimum wage orders or otherwise provided by New York state law or regulation 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 per employer, in an amount equal to but not greater than three thousand dollars per employee across all employers.

(d) Upon completion of a vesting period with an employer, an employee shall be entitled to receive the bonus and the employer shall be required to pay the bonus no later than the date specified under this subdivision, provided however that prior to such date the employee does not terminate, through action or inaction, the employment relationship with the employer, in accordance with any employment agreement, including a collectively bargained agreement, if any, between the employee and employer.

(e) 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.

(f) An employer shall be required to submit a claim for a bonus to the department no later than thirty days after an employee's eligibility for a bonus vests, in accordance with and upon issuance of the schedule issued by the commissioner or relevant agency commissioner.

(g) No portion of any funds 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.

(h) 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.

(i) The use of any accruals or other leave, including but not limited to sick, vacation, or time used under the family medical leave act, shall be credited towards and included in the calculation of the average number of hours worked per week over the course of the vesting period.

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 over-

payment 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; or

(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[~~.~~]; or

(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.

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 and shall not exceed one

thousand 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 the budget, shall be eligible for the health care and mental hygiene worker bonus. Notwithstanding the definition of base salary pursuant to paragraph (d) of subdivision 2 of section 367-w of the social services law, such bonus shall only be paid to employees who receive an annualized base salary of one hundred twenty-five 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 or whether the employee is eligible to receive a bonus from more than one employer.

§ 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. Bonuses under this act shall not be considered income for purposes of public benefits or other public assistance.

§ 8. Paragraph (a) of subdivision 8 of section 131-a of the social services law is amended by adding a new subparagraph (x) to read as follows:

(x) all of the income of a head of household or any person in the household, who is receiving such aid or for whom an application for such aid has been made, which is derived from the health care and mental hygiene worker bonuses under section three hundred sixty-seven-w of this

article or under the chapter of the laws of two thousand twenty-two which added this subparagraph.

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

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

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

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

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

4. Moneys appropriated for the purposes of this article to a municipality may include reimbursement of a municipality's fringe benefits, including but not limited to employee retirement funds, health insurance and federal old age and survivor's insurance. However, costs submitted under an application for state aid must be consistent with a municipality's documented fringe benefit costs and shall not exceed fifty per centum of the municipality's eligible personnel services.

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

PART F

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, standards for triage, treatment, and transportation protocols, workforce recruitment, development, and retention, 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, disaster medical care, the workforce, 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 system and agency sustainability assurance program. The commissioner, with the advice of the state emergency medical services council, may create an emergency medical services system and agency sustainability assurance program (hereinafter referred to as "the program"). Standards and metrics of the program may include but not be limited to: safety initiatives, emergency vehicle operations, operational competencies, planning, training, onboarding, workforce development, and other standards and metrics as determined by the commissioner in consultation with the state emergency medical services council, 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 program, and shall require each emergency medical services system and agency to perform regular and periodic review of program metrics and standards, including but not limited to identification of agency deficiencies and strengths, development of programs to improve agency metrics, strengthen system sustainability and operations, and improve the delivery of care. The department may contract for services to assist in the development and maintenance of these metrics and standards statewide with subject matter experts to

assist in the oversight of these metrics statewide. The department may delegate authority to oversee these metrics and standards 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 program set by the commissioner may be subject to enforcement actions, including but not limited to revocation, suspension, performance 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 services council, 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, agency types, transportation, workforce, communications, and other components of the emergency medical system to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality;

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

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

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

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

3. Each regional emergency medical services council shall develop and maintain a comprehensive regional emergency medical system plan, or adapt the statewide comprehensive emergency medical system plan to provide for a coordinated emergency medical system within the region. Such plans shall be subject to review by the state emergency medical services council 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. Such plans shall be subject to review by the regional emergency medical services council, the state emergency medical services 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 services training program. 1. The department shall establish, in consultation with the state emergency medical services council, a training program for emergency medical services 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 in consultation with the state emergency medical services council. 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 services council, shall establish minimum education standards, curriculums and requirements for all emergency medical services training programs. No person shall profess to provide emergency medical services training without the approval of the department.

3. The department is authorized to provide, either directly or through contract, emergency medical services training for emergency medical service practitioners and emergency medical system services personnel, develop and distribute training materials for use by instructors, and to recruit and offer training to 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. The department may delegate responsibilities to the state or regional emergency medical services councils to assist in the compliance, maintenance, and coordination of training programs.

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, in consultation with the state emergency medical services council, 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. Until such time as the state emergency medical system plan is established, the definition of determination of need will be developed by the department in consultation with the state emergency medical services council. 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 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, interfacility, or community paramedicine 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

Intentionally Omitted

PART H

Section 1. Sections 91 and 92 of part H of chapter 59 of the laws of 2011 relating to the year to year rate of growth of Department of Health state funds and Medicaid funding are REPEALED.

§ 2. This act shall take effect immediately.

PART I

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

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

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

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

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

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

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

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

PART J

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

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

§ 2. 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, including hospitals regulated pursuant to article eight of the education law, 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 section one hundred sixty-three of the state finance 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 section one hundred sixty-three of the state finance 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, including, but not limited to, public hospitals operated by a public benefit corporation (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.

(c) At least twenty-five percent of the funds shall be allocated exclusively for community-based health care providers, which for the purposes of this subdivision shall be defined as: a diagnostic and treatment center licensed or granted an operating certificate under article twenty-eight of the public health law; a mental health outpatient provider licensed or granted an operating certificate under article thirty-one of the mental hygiene law, a substance use disorder treatment provider licensed or granted an operating certificate under article thirty-two of the mental hygiene law, a program licensed under article forty-one of the mental hygiene law, a community-based program funded under the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports or through a local government unit as defined under article forty-one of the mental hygiene law, a home care provider certified or licensed pursuant to article thirty-six of the public health law, a primary care provider, a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law, a provider of health home services as authorized under section twenty-seven hundred three of the federal protection and affordable care act, a hospice provider licensed or granted an operating certificate under article forty of the public health law, or a family and child service provider licensed under article twenty-nine-I of the public health law, for the exclusive purpose of supporting the programs and services defined in this subdivision.

6. (a) Notwithstanding section one hundred sixty-three of the state finance 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 to applicants, without a competitive bid or request for proposal process, for technological and telehealth transformation projects.

(b) At least twenty-five percent of the funds shall be allocated exclusively for community-based health care providers, which for the purposes of this subdivision shall be defined as: a diagnostic and treatment center licensed or granted an operating certificate under article twenty-eight of the public health law; a mental health outpatient provider licensed or granted an operating certificate under article thirty-one of the mental hygiene law, a substance use disorder treatment provider licensed or granted an operating certificate under

article thirty-two of the mental hygiene law, a program licensed under article forty-one of the mental hygiene law, a community-based program funded under the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports or through a local government unit as defined under article forty-one of the mental hygiene law, a home care provider certified or licensed pursuant to article thirty-six of the public health law, a primary care provider, a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law, a provider of health home services as authorized under section twenty-seven hundred three of the federal protection and affordable care act, a hospice provider licensed or granted an operating certificate under article forty of the public health law, or a family and child service provider licensed under article twenty-nine-I of the public health law, for the exclusive purpose of supporting the programs and services defined in this subdivision.

7. Notwithstanding section one hundred sixty-three of the state finance 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 to applicants, without a competitive bid or a request for proposal process, to residential and community-based alternatives to the traditional model of nursing home care.

7-a. Notwithstanding section one hundred sixty-three of the state finance law, or any inconsistent provision of law to the contrary, up to four hundred million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request for proposal process, to support health care delivery, including for capital investment, debt retirement or restructuring for a

(a) general hospital, licensed pursuant to this chapter, where not less than thirty-six percent of the patients it treats receive medical assistance or are medically uninsured;

(b) diagnostic and treatment center, licensed pursuant to this chapter, where not less than thirty-six percent of the patients it treats receive medical assistance or are medically uninsured; or

(c) residential health care facilities, licensed pursuant to this chapter, where not less than seventy-five percent of the patients it treats receive medical assistance.

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 applicants 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 compe-

tence 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.

§ 4-a. The commissioner of health, in conjunction with the public health and health planning council, shall provide a joint report to the temporary president of the senate, the speaker of the assembly, and the chairs of the senate and assembly health committees by December 31, 2022, detailing the statutes, rules, and regulations, as well as other limitations or processes for the approval of health care facilities to operate in New York through licensure, certification, or other regulatory structure approved or authorized by the state and subdivisions thereof. The goal of the report shall be to identify potential barriers to operation that do not jeopardize the quality of care provided by health care facilities, and issue recommendations to address these barriers, for any individuals or entities that desire or are actively seeking to operate health care facilities in New York. The report shall include but not be limited to financial requirements for these facilities either directly or indirectly through costs associated with the approval process, such as fees, requirements for real property acquisition, and operational costs that may be experienced while an application is pending. The commissioner of health shall publish this report on the department of health website within thirty days of its transmittal to the legislature.

§ 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;

(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); and

(iv) any grant funds from the federal government, including but not limited to, funds received from the federal emergency management agency.

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

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

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

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

§ 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 appli-

cable 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 supplemental 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 sufficient 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 spec-

ified 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. This act enacts into law major components of legislation relating to medical and mental health care. 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. Subdivisions 2 and 3 of section 367-r of the social services law, subdivision 2 as amended and subdivision 3 as added by section 2 of part PP of chapter 56 of the laws of 2020, are amended to read as follows:

2. Medically fragile children **and adults**. (a) In addition, the commissioner shall further increase rates for private duty nursing services that are provided to medically fragile children to ensure the availability of such services to such children. **Furthermore, no later than sixty days after the chapter of the laws of two thousand twenty-two that amended this subdivision takes effect, increased rates shall be extended for private duty nursing services provided to medically fragile adults.** In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children **and adults** in a non-institutional setting as compared to an institutional setting. Medically fragile children shall, for the purposes of this subdivision, have the same meaning as in subdivision three-a of section thirty-six hundred fourteen of the public health law. **For purposes of this subdivision, "medically fragile adult" shall be defined as any individual who previously qualified as a medically fragile child but no longer meets the age requirement.** Such increased rates for services rendered to such children **and adults** may take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the private duty nursing service is provided, costs associated with the provision of private duty nursing services to medically fragile children **and 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 children **and adults**. Such increased rates shall be determined based on application of the case mix adjustment factor for AIDS home care program services rates as determined pursuant to applicable regulations of the department of health. The commissioner may promulgate regulations to implement the provisions of this subdivision.

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

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

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

3. Provider directory for fee-for-service private duty nursing services provided to medically fragile children **and 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 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)~~] **paragraphs (c) and (d)** of subdivision two of this section. The directory shall offer enrollment to all private duty nursing services providers to promote and ensure the participation in the directory of all nursing services providers available to serve medically fragile children **and adults**.

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

3-a. Medically fragile children **and adults**. Rates of payment for continuous nursing services for medically fragile children **and adults** provided by a certified home health agency, a licensed home care services agency or a long term home health care program shall be established to ensure the availability of such services, whether provided by registered nurses or licensed practical nurses who are employed by or under contract with such agencies or programs, and shall be established at a rate that is at least equal to rates of payment for such services rendered to patients eligible for AIDS home care programs; provided, however, that a certified home health agency, a licensed home care services agency or a long term home health care program that receives such enhanced rates for continuous nursing services for medically fragile children **and adults** shall use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide such services. In the case of services provided by certified home health agencies and long term home health care programs through contracts with licensed home care services agencies, rate increases received by such certified home health agencies and long term home health care programs pursuant to this subdivision shall be reflected in payments made to the registered nurses or licensed practical nurses employed by such licensed home care services agencies to render services to these children **and adults**. In establishing rates of payment under this subdivision, the commissioner shall consider the cost neutrality of such rates as related to the cost effectiveness of caring for medically fragile children **and adults** in a non-institutional setting as compared to an institutional setting. For the purposes of this subdivision, a medically fragile child shall mean a child who is at risk of hospitalization or institutionalization, including but not limited to children who are technologically-dependent for life or health-sustaining functions, require complex medication regimen or medical interventions to maintain or to improve their health status or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk, but who are capable of being cared for at home if provided with appropriate home care services, including but not limited to case management services and continuous nursing services. **For the purposes of this subdivision, a medically fragile adult shall mean any individual who previously qualified as a medically fragile child but no longer meets the age requirement.** The commissioner shall promulgate regulations to implement provisions of this subdivision and may also direct the providers specified in this subdivision to provide such additional information and in such form as the commissioner shall determine is reasonably necessary to implement the provisions of this subdivision.

§ 3. This act shall take effect immediately.

SUBPART B

Section 1. Legislative findings and intent. The legislature finds that the Program of All-Inclusive Care for the Elderly ("PACE") is a federally recognized model of comprehensive care for persons 55 years of age or older, qualifying for nursing home levels of care who wish to remain in their community (see, Sections 1894 and 1934 to Title XVIII of the Social Security Act; 42 CFR 460). The PACE program includes both Medicaid and Medicare covered benefits. Federal preemption of state laws with respect to PACE has inhibited the ability of state agencies - particularly the New York State Department of Health ("DOH") - to regulate PACE plans similarly to other public and commercial health plans.

The legislature further finds that: Research has demonstrated that PACE has delivered marked improvements for enrollees in the programs nationwide including, but not limited to reduced hospitalizations and readmissions; reduced reliance on emergency medical services; improved quality of life; and higher satisfaction with the totality of their care. In conjunction with these improvements, the implementation of PACE in New York has realized significant savings to the state's Medicaid program compared to costs that would have been incurred under fee-for-service. As neither a fee-for-service model nor a managed long-term care plan, PACE represents a unique approach to care and coverage for those with long-term care needs. PACE organizations are currently required to be licensed and are regulated under multiple provisions of state and federal law. Uniformity of regulation of PACE organizations promotes both efficiency for organizations and for the state.

For all the foregoing reasons, it is the intent of the legislature through this act to provide a more efficient and uniform structure to promote the prudent development of PACE organizations in the state, to promote better health outcomes for New Yorkers enrolled in such programs, and to realize administrative efficiencies through these programs. It is the intent of the legislature to recognize PACE organizations as integrated providers of care and to that end, nothing in this article is intended to construe PACE organizations as a managed care organization as defined by article 44 of the public health law.

§ 2. 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. §1395eee and established in accordance with federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997.

2. "Program of all-inclusive care for the elderly" or "PACE program" means the federally recognized model of comprehensive care that provides

Medicaid and Medicare covered services to eligible individuals, and shall include those programs defined as "operating demonstrations" by section forty-four hundred three-f of this chapter.

3. "PACE center" means a diagnostic and treatment center established under article twenty-eight of this chapter and operated by a PACE organization where primary care and other services are furnished to enrollees of such program.

4. "PACE program agreement" shall have the same meaning as defined by 42 U.S.C. § 1395eee.

§ 2999-t. PACE program establishment. 1. Notwithstanding any inconsistent provision of law to the contrary, the commissioner shall establish a state program of all-inclusive care for the elderly, 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 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 program, as provided for pursuant to 42 U.S.C. § 1395eee and 42 U.S.C. § 1396u-4 shall not be waived or modified. New York state PACE organization requirements shall include:

(a) The provision 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. The department may enter into contracts with public or private organizations for implementation of the state's PACE program, and may enter into additional contracts as necessary to implement such program, or any other requirement deemed necessary to provide comprehensive community-based, risk-based and capitated long-term care to eligible populations. Additionally:

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

(b) PACE organizations licensed under this article shall be authorized to act as fiscal intermediaries for their enrollees without entering into additional contracts with the state to conduct such duties on behalf of enrollees.

3. Licensure. In setting forth requirements to establish the state's PACE program, the department shall provide for a unified licensure process for PACE organizations that is inclusive of program requirements set forth under articles forty-four, thirty-six, and twenty-eight 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. For the purposes of subdivision one of section sixty-five hundred twenty-seven of the education law, a PACE organization shall be deemed to be a health maintenance organization as defined by section forty-four hundred one of this chapter.

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 programs;

(b) Provide oversight of PACE organization operations in coordination with the centers for Medicare and Medicaid services, including any rules appropriate for the safe, efficient and orderly administration of the program; and

(c) Develop a single process for PACE organizations to complete all reports, audits, surveys, and other data or information collection required by federal, state or local authorities.

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

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

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

(iii) Reside within the PACE program-approved service area; and

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

(b) 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.

2. Notwithstanding any law or regulation to the contrary, if federal law or regulation sets forth broader eligibility or enrollment requirements than those set forth under subdivision one of this section, eligibility for the PACE program shall conform to such federal requirements.

3. Enrollment and participation by individuals in the PACE program shall be voluntary.

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

(a) All Medicare-covered items and services;

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

(c) 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 PACE program enrollees.

1. Methodology. To the extent required by federal law, such rate methodologies for PACE organizations shall result in a payment amount no greater than the amount that would otherwise have been paid for comparable services provided pursuant to the state plan if the participants were not enrolled in the PACE program. PACE program rates shall be set in compliance with relevant centers for Medicare and Medicaid services rate setting rules and guidance.

2. Transparency. The department shall provide, or shall require any independent actuary used to review PACE program reimbursement rates to provide, to PACE organizations the documents and information regarding PACE program reimbursement rates submitted to the centers for Medicare and Medicaid services in a form and time frame consistent with the requirements for the department to provide or cause to be provided documents and information to Medicaid managed care providers under paragraph (c) of subdivision eighteen of section three hundred sixty-four-j of the social services law.

§ 2999-y. Severability. If any provision of this article, or any application of any provision of this article, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, such violation or inconsistency shall not affect the validity or effectiveness of any other provision of this article, or of any other application of any provision of this article, which can be given effect without such provision or application; and to such end, the provisions and applications of this article shall be severable.

§ 3. Paragraph (c) of subdivision 18 of section 364-j of the social services law, as added by section 55 of part B of chapter 57 of the laws of 2015, is REPEALED.

§ 4. Paragraph (c) of subdivision 18 of section 364-j of the social services law, as added by section 40-c of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(c) In setting such reimbursement methodologies, the department shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care. **The department shall require the independent actuary selected pursuant to paragraph (b) of this subdivision to provide a complete actuarial memorandum, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates, to managed care providers thirty days prior to submission of such rates to the centers for Medicare and Medicaid services for approval. Managed care providers may request additional review of the actuarial soundness of the rate setting process and/or methodology.**

§ 5. This act shall take effect January 1, 2023, provided, however, that the amendments made to section 364-j of the social services law made by section four of this act shall not affect the repeal of such section and shall be deemed repealed therewith. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

SUBPART C

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

§ 26. Notwithstanding any provision of law to the contrary and subject to the availability of federal financial participation, for periods on and after April 1, 2011, clinics certified pursuant to [~~articles 16,~~] **article** 31 or 32 of the mental hygiene law shall be subject to targeted Medicaid reimbursement rate reductions in accordance with the provisions of this section. Such reductions shall be based on utilization thresholds which may be established either as provider-specific or patient-specific thresholds. Provider-specific thresholds shall be based on average patient utilization for a given provider in comparison to a peer based standard to be determined for each service. The commissioners of the office of mental health[~~, the office for persons with developmental disabilities,~~] and the office of alcoholism and substance abuse services, in consultation with the commissioner of health, are authorized to waive utilization thresholds for patients of clinics certified pursuant to article [~~16,~~] 31[~~,~~] or 32 of the mental hygiene law who are enrolled in specific treatment programs or otherwise meet criteria as may be specified by such commissioners. When applying a provider-specific threshold, rates will be reduced on a prospective basis based on

the amount any provider is over the determined threshold level. Patient-specific thresholds will be based on annual thresholds determined for each service over which the per visit payment for each visit in excess of the standard during a twelve month period shall be reduced by a pre-determined amount. The thresholds, peer based standards and the payment reductions shall be determined by the department of health, with the approval of the division of the budget, and in consultation with the office of mental health[~~, the office for people with developmental disabilities~~] and the office of alcoholism and substance abuse services, and any such resulting rates shall be subject to certification by the appropriate commissioners pursuant to subdivision (a) of section 43.02 of the mental hygiene law. The base period used to establish the thresholds shall be the 2009 calendar year. The total annualized reduction in payments shall be not more than $10,900,000 for Article 31 clinics[~~, not more than $2,400,000 for Article 16 clinics,~~] and not more than $13,250,000 for Article 32 clinics. The commissioner of health may promulgate regulations to implement the provisions of this section.

§ 2. This act shall take effect immediately.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or 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 P

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 6. Intentionally omitted.

§ 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. This act shall take effect immediately; provided however that 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 section eight 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.

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.

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

3-a. Alternate eligibility. A person shall also be eligible to receive coverage for health care services under this title, without regard to federal financial participation, if they are a resident of New York state, have a household income below two hundred fifty percent of the federal poverty line as defined and annually revised by the United States department of health and human services for a household of the same size, and are ineligible for federal financial participation in the basic health program under 42 U.S.C. section 18051 on the basis of immigration status, but otherwise meet the eligibility requirements in paragraphs (b), (c), and (d) of subdivision three of this section. An applicant who fails to make an applicable premium payment shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

§ 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 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 for and receiving coverage for health care services pursuant to this title is eligible 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;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs (2) or (4) of paragraph (b) of subdivision 1 of section three hundred sixty-six of the social services law 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 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 for and receiving coverage for health care services pursuant to this title is eligible 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;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs (2) or (4) of paragraph (b) of subdivision 1 of section three hundred sixty-six of the social services law 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) section one-a of this act shall take effect on January 1, 2023;

(b) 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;

(c) section four of this act 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

(d) 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. Legislative findings. The legislature finds that New York has a long history of advancing gender equity and, as part of that effort, reproductive health.

The legislature additionally finds that access to the full range of health benefits, as guaranteed under the laws of this state, provides all New Yorkers with the opportunity to lead healthier and more fulfilling lives.

The legislature also finds that neither a person's income level nor the type of health insurance they utilize should prevent them from having access to a full range of reproductive health care, including abortion care.

The legislature additionally finds that restrictions and barriers to health coverage for reproductive health care have a disproportionate impact on low-income people, people of color, immigrants, and young people and that these individuals are often already disadvantaged in their access to resources, information, and services.

The legislature also finds that the exclusion of coverage for reproductive health care services for women and those with the capacity to become pregnant is discrimination on the basis of sex and pregnancy.

The legislature finds that abortion care is part of pregnancy-related care, and failure to provide coverage for the full range of pregnancy-related care interferes with an individual's personal health care decision making, their overall health and well-being and with their constitutionally protected right to safe and legal abortion care.

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

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

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

(C) If the superintendent concludes that enforcement of this paragraph may adversely affect the allocation of federal funds to the state, the superintendent may grant an exemption to the requirements of this paragraph, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

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

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

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

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

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

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

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

(D) If the superintendent concludes that enforcement of this paragraph may adversely affect the allocation of federal funds to the state, the superintendent may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

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

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

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

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

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

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

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

(4) If the superintendent concludes that enforcement of this subsection may adversely affect the allocation of federal funds to the state, the superintendent may grant an exemption to the requirements, but only to the minimum extent necessary to ensure the continued receipt of federal funds.

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

§ 6. 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.

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 March 1, 2023. The commissioner of health shall immediately take all steps necessary and shall use best efforts to secure federal financial participation for eligible beneficiaries under title XIX of the social security act, for the purposes of this act, including the prompt submission of appropriate amendments to the title XIX state plan.

PART T

Intentionally Omitted

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. Section 2511 of the public health law is amended by adding subdivision 22 to read as follows:

22. Notwithstanding the provisions of this title and effective on and after January first, two thousand twenty-three, the consultative, review, and approval functions of the superintendent of financial services related to administration of the child health insurance plan are no longer applicable and references to those functions in this title shall be null and void. The child health insurance plan set forth in this title shall be administered solely by the commissioner. All child health insurance plan policies reviewed and approved by the superintendent of financial services in accordance with section eleven hundred twenty of the insurance law shall remain in effect until the commissioner establishes a process to review and approve member handbooks in accordance with the requirements of Title XXI of the federal social security act and implementing regulations, and such member handbooks are issued by approved organizations to enrollees in place of child health

insurance plan policies which were subject to review under section eleven hundred twenty of the insurance law.

§ 6. This act shall take effect immediately; provided, however, that sections one, three and four of this act shall take effect January 1, 2023 and sections two and five of this act shall take effect April 1, 2022.

PART V

Section 1. Paragraph (y) of subdivision 2 of section 2999-cc of the public health law, as amended by section 3 of part F of chapter 57 of the laws of 2021, is amended and a new subdivision 8 is added to read as follows:

(y) any [~~other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, or the commissioner of the office for people with developmental disabilities pursuant to regulation~~] health care provider who:

(i) possesses the requisite license, certification, registration, authorization or credentialing to provide a health care service in New York state; and

(ii) reasonably determines that it is clinically appropriate to deliver such health care service via telehealth.

8. "Health care plan" means an entity (other than a health care provider) that approves, provides, arranges for, or pays for health care services, including but not limited to:

(a) a health maintenance organization licensed under article forty-three of the insurance law;

(b) a health maintenance organization or other organization certified under article forty-four of this chapter;

(c) an insurer or corporation subject to the insurance law; and

(d) the medical assistance program under title eleven of article five of the social services law ("medicaid"); the child health plus program under title one-A of article twenty-five of this chapter, and the basic health program under section three hundred sixty-nine-gg of the social services law.

§ 2. Section 2999-dd of the public health law, as amended by section 4 of subpart C of part S of chapter 57 of the laws of 2018, subdivision 1 as amended by chapter 124 of the laws of 2020, subdivisions 3 and 4 as added by chapter 328 of the laws of 2020, is amended to read as follows:

§ 2999-dd. Telehealth delivery of services. 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; 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.~~] (a) A health care service may be delivered by means of telehealth by a telehealth provider otherwise authorized to perform that service. A health care service delivered by telehealth shall be with the consent of the patient or a person authorized to consent for the patient. The consent shall be documented in the patient's medical record.

(b) In-person contact between a telehealth provider and a patient prior to the delivery of health care services via telehealth shall not be required, unless the provider determines it to be clinically necessary.

2. (a) A health care plan shall cover a service, regardless of whether it is provided by telehealth, if the service would otherwise be covered by the health care plan and the provider is otherwise covered by the health care plan.

(b) A health care plan shall reimburse a treating or consulting health care provider for health care services appropriately delivered by telehealth on the same basis, at the same rate, and to the same extent that the health care plan reimburses for the service when provided through in-person diagnosis, consultation, or treatment.

(c) A health care plan may subject the coverage of a telehealth service to copayments, coinsurance or deductibles if they are at least as favorable to the enrollee as would apply if the service is not provided by telehealth.

(d) This article does not alter any obligation a health care plan may have to ensure that enrollees have access to all covered services through an adequate network of contracted providers.

(e) With respect to health care plans under paragraph (d) of subdivision eight of section 2999-cc of this article (medicaid, child health plus, and the basic health plan), this article shall only apply where there is federal financial participation. The commissioner shall make state plan amendments and seek federal waivers as necessary to obtain that federal financial participation.

3. The department of health, the office of mental health, the office of [~~alcoholism and substance abuse services~~] addiction services and supports, and the office for people with developmental disabilities shall coordinate on the issuance of a single guidance document, to be updated as appropriate, that shall: (a) identify any differences in regulations or policies issued by the agencies, including with respect to reimbursement [~~pursuant to section three hundred sixty-seven-u of the social services law~~]; and (b) be designed to assist consumers, providers, and health care plans in understanding and facilitating the appropriate use of telehealth in addressing barriers to care.

[~~3.~~] 4. The authority of the department of financial services to establish and enforce minimum standards for accident and health insurance under articles thirty-two and forty-three of the insurance law shall include enforcement of telehealth standards set forth in this article.

5. (a) Dental telehealth services shall adhere to the standards of appropriate patient care required in other dental health care settings, including but not limited to appropriate patient examination, taking of x-rays, and review of a patient's medical and dental history. All dental telehealth providers shall identify themselves to patients, including providing the professional's New York state license number. No dental telehealth provider shall attempt to waive liability for its telehealth services in advance of delivering such telehealth services and no dental telehealth provider shall attempt to prevent a patient from filing any complaint with any governmental agency or authority.

(b) This subdivision shall not be construed to diminish requirements for other telehealth services.

[~~4.~~] 6. Nothing in this article shall be deemed to allow any person to provide any service for which a license, registration, certification or

other authorization under title eight of the education law is required and which the person does not possess.

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

§ 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 commissioner of health, the superintendent of the department of financial services, the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, and the commissioner of the office for people with developmental disabilities shall make regulations and take other actions reasonably necessary to implement this act on that date.

PART W

Intentionally Omitted

PART X

Intentionally Omitted

PART Y

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

§ 20-c. Certification of marriage; new certificate in case of subsequent change of name or gender. 1. A new marriage certificate shall be issued by the town or city clerk where the marriage license and certificate was issued, upon receipt of proper proof of a change of name or gender designation. Proper proof shall consist of: (a) a judgment, order or decree affirming a change of name or gender designation of either party to a marriage; (b) an amended birth certificate demonstrating a change of name or gender designation; 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. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

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

subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, [~~and~~] between July 1, 2021 and June 30, 2022**, and between July 1, 2022 and June 30, 2023** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with

respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

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

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 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**.

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part K of chapter 57 of the laws of 2021, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insuffi-

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

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

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

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

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

1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022**, or covering the period July 1, 2022 to June 1, 2023** that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

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

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

§ 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 4 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [~~2022~~] **2023**; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [~~2022~~] **2023**, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [~~2022~~] **2023** policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent

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

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part K of chapter 57 of the laws of 2021, are amended to read as follows:

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

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

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

§ 6. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part K of chapter 57 of the laws of 2021, is amended to read as follows:

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

dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand [~~twenty-one~~] twenty-two, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [~~twenty-one~~] twenty-two and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [~~twenty-one~~] twenty-two.

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

PART AA

Intentionally Omitted

PART BB

Intentionally Omitted

PART CC

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 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. Intentionally omitted.

§ 6. Intentionally omitted.

§ 7. Intentionally omitted.

§ 8. Intentionally omitted.

§ 9. Intentionally omitted.

§ 10. Intentionally omitted.

§ 11. Intentionally omitted.

§ 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.

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, and a state fiscal year 2023-2024 cost of living adjustment (COLA), effective April 1, 2023, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in paragraphs (i), (ii), (iii), (iv), (v), and (vi) of subdivision four of this section. The COLA established herein shall be applied to the appropriate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the department of health (DOH) shall be made as reimbursement for the state share of medical assistance.

2. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefore, for the period of April 1, 2022 through March 31, 2023, and for the period of April 1, 2023 through March 31, 2024, 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, and April 1, 2023. 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, and the period commencing on April 1, 2023 and ending March 31, 2024, the commissioners shall not apply any other new cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other cost of living type increases, inflation factors, or trend factors" as defined in this subdivision shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic Public Health Emergency.

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, operated by employees under the jurisdiction of the office of mental health.

(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;

(4) The number of mobile crisis teams dispatched;

(5) The number of individuals engaged by mobile crisis teams including any support provided beyond the resolution of an initial crisis;

(6) The number of individuals transported by mobile crisis teams to a crisis receiving and stabilization service center or other mental health crisis service;

(7) The number of such individuals transferred by mobile crisis team responders to the custody of law enforcement or transported to an emergency room or inpatient mental health service;

(8) The number of times a mobile crisis team was the first responder to a mental health crisis and had to request deployment of law enforcement, including the reason for the request, and the outcome of the law enforcement response; and

(9) The age, gender, race, ethnicity, national origin, and high risk category of the individual, if reasonably ascertainable, of individuals contacted, transported, or transferred by each mobile crisis team.

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

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

§ 3. This act shall take effect immediately.

PART FF

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

5. 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. Beginning April first, two thousand twenty-two, the department shall also post on its website the list of managed care providers that provided a recovery of premiums under this section, a detailed accounting of the amount that was recovered from each provider, and the dates that the recovery was applied to, beginning with recoveries from two thousand thirteen. After the initial posting of this information on its website, the department shall update it on an annual basis by December thirty-first of each year.

§ 1-a. Subdivision 2 of section 364-j of social services law is amended by adding a new paragraph (d) to read as follows:

(d) Effective on and after April first, two thousand twenty-two, whenever the commissioner of health makes changes to the terms, conditions or time frames contained in the model contract with managed care providers in the managed care program under this section, public notice detailing the changes shall be provided on the department's website and through publication as a public notice in the state register prior to finalizing such changes or submitting the amended contract to the federal centers for medicare and Medicaid services for approval, if required. This public notice shall also apply to any request for proposals issued by the department for managed care providers to participate in the managed care program.

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

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~~] 2023.

§ 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 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 required to maintain a stock of at least one version of an opioid antagonist and any drug on the single statewide formulary for 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

Intentionally Omitted

PART KK

Intentionally Omitted

PART LL

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

§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 36, 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of the office of mental health, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of [~~alcoholism and substance abuse~~] addiction services and supports, or the office of mental health for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~1~~] 18 of part [~~P~~] E of chapter 57 of the laws of [~~2017~~] 2019 through March 31, [~~2023~~] 2027 for patients in the city of New York, for all rate periods on and after the effective date of section [~~1~~] 18 of part [~~P~~] E of chapter 57 of the laws of [~~2017~~] 2019 through March 31, [~~2023~~] 2027 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through March 31, [~~2023~~] 2027 for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the

commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of [~~alcoholism and substance abuse~~] addiction services and supports and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of [~~alcoholism and substance abuse~~] addiction services and supports and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

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

child health insurance program pursuant to title 1-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

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

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and [~~alcoholism and substance abuse~~] addition 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~~] 2023.

§ 2. Intentionally omitted.

§ 3. This act shall take effect immediately.

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

Intentionally Omitted

PART PP

Section 1. Subdivision 4 of section 364-j of the social services law is amended by adding two new paragraphs (w) and (x) to read as follows:

(w) Notwithstanding any provision of law to the contrary, administrative fees paid to a managed care provider or a pharmacy benefit manager under the medical assistance program shall be reduced for the purpose of increasing reimbursement rates to retail pharmacies under the Medicaid managed care program. Beginning on and after July first, two thousand twenty-two, all reimbursement paid by Medicaid managed care plans to retail pharmacies shall include a professional dispensing fee and the drug acquisition cost for each outpatient drug dispensed at no less than the amount established under the fee-for-service program, as defined in section three hundred sixty-seven-a of this title, regardless of whether such reimbursement is paid directly by the Medicaid managed care plan or passed through a pharmacy benefit manager or other entity. The reimbursement provided for under this paragraph shall not apply to any existing reimbursement arrangements involving an eligible provider under section 340B of the federal public health services act or a comprehensive HIV special needs plan under section forty-four hundred three-c of the public health law under the medical assistance program. No managed care provider or pharmacy benefit manager shall reimburse a pharmacy owned by or affiliated with such entity at a higher rate than that paid by such entity to a pharmacy it does not own or is not otherwise affiliated with.

(x) Notwithstanding any provision of law to the contrary, a managed care provider or pharmacy benefit manager acting on its behalf, as defined in section two hundred eighty-a of the public health law, shall not deny any retail pharmacy the opportunity to participate in another provider's pharmacy network under the medical assistance program at preferred participation status, provided that such retail pharmacy agrees to the same reimbursement amount, as defined in paragraph (w) of this subdivision, and is able to fill and dispense prescription and over-the-counter medications for those enrolled in the medical assistance program.

§ 2. Section 280-a of the public health law is amended by adding a new subdivision 6 to read as follows:

6. Delivery option. Notwithstanding any provision of law to the contrary, no pharmacy benefit manager shall limit the option for an individual receiving prescription or over-the-counter medications to receive such medications from their local, non-mail order pharmacy of choice via delivery including in-person delivery, United States postal service or other mail or courier service. No restrictions, prohibitions or prior authorization requirements shall be based on the individual's choice in delivery type or distance from a pharmacy.

§ 3. This act shall take effect on the thirtieth day after it shall have become a law; provided, however, that:

(a) the amendments to subdivision 4 of section 364-j of the social services law made by section one of this act shall take effect July 1, 2022;

(b) if this act shall have become a law after such effective date it shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 2022;

(c) the amendments to subdivision 4 of section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

(d) if chapter 828 of the laws of 2021 shall not have taken effect on or before such effective date then section two of this act shall take effect on the same date and in the same manner as such chapter of the laws of 2021 takes effect.

PART QQ

Section 1. Subparagraph (i) of paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by section 2 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(i) personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), (iv)[~~, (v)~~] and (vi) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a qualified independent physician selected or approved by the department of health, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

§ 2. Subparagraph (v) of paragraph (e) of subdivision 2 of section 365-a of the social services law is REPEALED.

§ 3. Paragraph (c) of subdivision 2 of section 365-f of the social services law, as amended by section 3 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(c) has been determined by the social services district, pursuant to an assessment of the person's appropriateness for the program, conducted with an appropriate long term home health care program, a certified home health agency, or an AIDS home care program or pursuant to the personal care program, as being in need of home care services or private duty nursing and [~~as needing at least limited assistance with physical maneuvering with more than two activities of daily living, or for persons with a dementia or Alzheimer's diagnosis, as needing at least supervision with more than one activity of daily living, provided that the provisions related to activities of daily living in this paragraph shall only apply to persons who initially seek eligibility for the program on or after October first, two thousand twenty, and~~] who is able and willing or has a designated representative, including a legal guardian able and willing to make informed choices, or a designated relative or other adult who is able and willing to assist in making informed choices, as to the type and quality of services, including but not limited to such services as nursing care, personal care, transportation and respite services; and

§ 4. This act shall take effect immediately.

PART RR

Section 1. The public health law is amended by adding a new section 3614-f to read as follows:

§ 3614-f. Fair pay for home care. 1. For the purpose of this section, "home care aide" shall have the same meaning defined in section thirty-six hundred fourteen-c of this article.

2. Beginning January first, two thousand twenty-three, the minimum wage for a home care aide shall be no less than one hundred and fifty percent of the higher of: (a) the otherwise applicable minimum wage under section six hundred fifty-two of the labor law, or (b) any other-wise applicable wage rule or order under article nineteen of the labor law.

3. Where any home care aide is paid less than required by this section, the home care aide, or the commissioner of labor acting on behalf of the home care aide, may bring an action under article six or nineteen of the labor law.

4. (a) The commissioner shall establish a regional minimum hourly base reimbursement rate for all providers employing workers subject to the minimum wage provisions established in subdivision one of this section. The regional minimum hourly base reimbursement rate shall be based on regions established by the commissioner, provided that for areas subject to section thirty-six hundred fourteen-c of this article, each area with a different prevailing rate of total compensation, as defined in that section, shall be its own region.

(b) For the purposes of this section, "regional minimum hourly base reimbursement rate" means a reimbursement rate that reflects the average combined costs associated with the provision of direct service inclusive of, but not limited to, overtime costs; all benefits; all payroll taxes, including but not limited to federal insurance contributions act, medi-care, federal unemployment tax act, state unemployment insurance, disa-bility insurance, workers' compensation, and the metropolitan transpor-tation authority tax; related increases tied to base wages such as compression; reasonable administrative costs as defined by the commis-sioner; allowances for capital costs; the development of profit or reserves as allowable by law or regulations of the commissioner; and any additional supplemental payments.

5. (a) The initial regional minimum hourly base reimbursement rate shall be no less than the following:

(i) thirty-eight dollars and fifty cents per hour in the wage parity region, encompassing all counties subject to section thirty-six hundred fourteen of this article; and

(ii) thirty-eight dollars and eighteen cents per hour for the counties in the remainder of the state.

(b) For consumer directed personal assistance services provided under section three hundred sixty-five-f of the social services law, the initial regional minimum hourly base reimbursement rate shall reflect the rates established in paragraph (a) of this subdivision, provided that the commissioner may reduce such rates by no more than twelve and nine-tenths percent. In the event that such reduction occurs, a per member, per month increase reflective of actual administrative and general costs, adjusted to reflect regional differences as regions are defined in this section, shall be made to fiscal intermediaries adminis-tering such programs. If the department or a managed care organization chooses not to utilize the per member, per month payment established pursuant to this paragraph, the regional minimum hourly base reimburse-ment rate for that region, as defined in paragraph (a) of this subdivi-sion, shall apply.

6. No payment made to a provider who employs home care aides subject to this section that is less than the regional minimum hourly base reimbursement rate established by the commissioner for a region for services provided under authorization by a local department of social services, a managed care provider under section three hundred sixty-four-j of the social services law, or a managed long-term care provider under section forty-four hundred-f of this chapter shall be deemed adequate.

(a) The commissioner shall submit any and all necessary applications for approvals and/or waivers to the federal centers for medicare and medicaid services to secure approval to establish minimum hourly base reimbursement rates and make state-directed payments to providers for the purposes of supporting wage increases.

(b) Directed payments shall be made to such providers of medicaid services through contracts with managed care organizations where applicable, provided that the commissioner ensures that such directed payments are in accordance with the terms of this section.

(c) The commissioner shall ensure that managed care capitation is adjusted to ensure rate adequacy for the managed care organizations.

7. Nothing in this section shall preclude providers employing home care aides covered under this section or payers from contracting for services at rates higher than the regional minimum hourly base reimbursement rate if the parties agree to such terms.

8. The commissioner shall publish and post regional minimum hourly base reimbursement rates annually and shall take all necessary steps to advise commercial and government programs payers of home care services of the regional minimum hourly base reimbursement rates and require other state authorized payers to reimburse providers of home care services at the minimum hourly base reimbursement rate.

9. Following the initial established regional minimum hourly base reimbursement rate established under this section, the commissioner shall annually adjust the regional hourly base reimbursement rate for each region to reflect costs or other increases in wages, benefits, or other requirements. The commissioner shall develop a methodology for annual increases, taking into consideration relevant data sources, including but not limited to information from certified cost reports and statistical reports submitted to the department by providers employing individuals subject to this section for the prior calendar year, consumer price index increases; subsequent pandemic or other public health emergencies; and other relevant economic factors. Prior to finalizing such methodology, the commissioner shall establish a public workgroup that shall include provider, consumer, managed care organization, and labor representatives from each geographical region in which there is an established regional minimum hourly base reimbursement rate; statewide associations; and other stakeholders to inform the process. The commissioner shall publish and take public input on the proposed methodology to be used to update regional minimum hourly base reimbursement rates.

10. Annual increases to the regional minimum hourly base reimbursement rates shall be issued and posted by the department by September thirtieth of the prior calendar year to when such rates shall take effect.

11. For years in which rate adjustments to the regional minimum hourly base reimbursement rate have not been calculated prior to the start of the calendar year, the previous year's rate shall remain in place until the new rate is calculated. If it is determined that retroactive rate adjustments are necessary, payment adjustments will be made as a direct pass through to providers within sixty days of the adjusted rate.

§ 2. Section 3614-d of the public health law, as added by section 49 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

§ 3614-d. Universal standards for coding of payment for medical assistance claims for long term care. Claims for payment submitted under contracts or agreements with insurers under the medical assistance program for home and community-based long-term care services provided under this article, by fiscal intermediaries operating pursuant to section three hundred sixty-five-f of the social services law, and by residential health care facilities operating pursuant to article twenty-eight of this chapter shall have standard billing codes. Such insurers shall include but not be limited to Medicaid managed care plans and managed long term care plans. Such payments shall be based on universal billing codes approved by the department or a nationally accredited organization as approved by the department; provided, however, such coding shall be consistent with any codes developed as part of the uniform assessment system for long term care established by the department **and shall include, for any entity operating pursuant to this article or section three hundred sixty-five-f of the social services law that is unable to control the cumulative hours worked by an individual in a given payroll period, a code that is specific to the hourly cost of services at an overtime rate**.

§ 3. The state finance law is amended by adding a new section 91-h to read as follows:

§ 91-h. Fair pay for home care fund. 1. There is hereby established in the joint custody of the commissioner of taxation and finance and the comptroller, a special fund to be known as the "fair pay for home care fund".

2. The fund shall consist of, but not be limited to:

a. revenues and federal medical assistance percentage reimbursements in excess of the standard reimbursement received by the department of health pursuant to section thirty-seven of part B of chapter fifty-seven of the laws of two thousand fifteen;

b. an amount equal to savings from the permanent conversion or decertification of residential health care facility beds, as defined in section twenty-eight hundred one or twenty-eight hundred two of the public health law;

c. any unspent monies from the New York works economic development funds or a life sciences initiative created by section one of chapter fifty-four of the laws of two thousand seventeen which were originally appropriated prior to the two thousand nineteen state fiscal year which have not been bound by a contract as of April first two thousand twenty-two and which are not otherwise legally required to be spent on capital projects under bonding requirements through the dormitory authority of New York state or other bonding entity; and

d. any grants, gifts or bequests received by the state for the purposes of the fund under this section.

3. Monies of the fund shall be distributed to the commissioner of health, or the commissioner's designee, for the purpose of increasing medical assistance reimbursements under title eleven of article five of the social services law to entities subject to minimum wage requirements for home care aides under section thirty-six hundred fourteen-f of the public health law, provided that the monies of this fund shall be utilized to offset general fund expenses related to implementation and ongoing costs of section thirty-six hundred fourteen-f of the public

health law and shall not be the sole source of funds made available to meet the requirements established by such section.

§ 4. Paragraph (c) 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 known and projected department of health state fund Medicaid expenditures, as amended by section 1 of part CCC of chapter 56 of the laws of 2020, is amended to read as follows:

(c) Projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, minimum wage increases, increases to the mandatory base wage for home care workers pursuant to article 36 of the public health law, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund and state costs or savings from the basic health plan. Such projections may be adjusted by the director of the budget to account for increased or expedited department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

§ 5. Paragraph (a) of subdivision 3 of section 3614-c of the public health law is amended by adding a new subparagraph (v) to read as follows:

(v) for all periods on or after January first, two thousand twenty-three, the cash portion of the minimum rate of home care aide total compensation shall be the minimum wage for home care aides in the applicable region, as defined in section thirty-six hundred fourteen-f of this article. The benefit portion of the minimum rate of home care aide total compensation shall be four dollars and eighty-four cents.

§ 6. Subparagraph (iv) of paragraph (b) of subdivision 3 of section 3614-c of the public health law, as amended by section 1 of part OO of chapter 56 of the laws of 2020, is amended and a new subparagraph (v) is added to read as follows:

(iv) for all periods on or after March first, two thousand sixteen, the cash portion of the minimum rate of home care aide total compensation shall be ten dollars or the minimum wage as laid out in paragraph (b) of subdivision one of section six hundred fifty-two of the labor law, whichever is higher. The benefit portion of the minimum rate of home care aide total compensation shall be three dollars and twenty-two cents[.];

(v) for all periods on or after January first, two thousand twenty-three, the cash portion of the minimum rate of home care aide total compensation shall be the minimum wage for the applicable region, as defined in section thirty-six hundred fourteen-f of this chapter. The benefit portion of the minimum rate of home care aide total compensation shall be three dollars and eighty-nine cents.

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

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

PART SS

Section 1. Short title. This act shall be known and may be cited as the "quality incentive vital access provider program (QIVAPP) act".

§ 2. The public health law is amended by adding a new section 4403-ff to read as follows:

§ 4403-ff. Quality incentive vital access provider program. 1. Monies shall be made available, subject to appropriation, to reward investments in qualified home and personal care providers and networks, in accordance with the provisions of this section, by managed long-term care plans established pursuant to section forty-four hundred three-f of this article.

2. Notwithstanding any contrary provisions of law, the commissioner shall make available additional rate add-ons to eligible plans, in a manner determined by the commissioner, to be used to increase reimbursement to qualified providers where eligible plan applicants and qualified providers meet the following standards:

(a) The plan must show full compliance with this chapter, including all wage and hour requirements;

(b) The plans pay a qualified provider a base contracted amount that reflects the cost of investments for home and personal care aide services effective July first, two thousand twenty-two, and begin such payments for services provided after this date in conjunction with contract payment terms;

(c) The plan identifies a qualified provider that maintains or participates in a specialty training program for home health aides and personal care aides in excess of the training required in 18 NYCRR 505.14(e)(2)(ii) and 10 NYCRR 766.11, and shall provide a letter of support for that training program from labor organizations;

(d) The plan identifies qualified network providers that have a written quality assurance program that has been successfully implemented;

(e) The plan identifies qualified network providers that provide comprehensive health insurance coverage to their employees that meets or exceeds criteria identified by the department; and

(f) The plan provides network survey data to the department and any other data as needed.

3. Notwithstanding subdivisions one and two of this section, no plan applicant shall receive quality incentive rate add-ons under this chapter and no qualified provider shall receive increased reimbursement under this chapter if either fail to meet any of the requirements of subdivision two of this section. Provided, however, if an otherwise qualified provider cannot meet any of these standards, the department will consider exceptions on a case by case basis, if they can be justified.

4. The commissioner is authorized to promulgate any rules or regulations necessary to implement the quality incentive vital access program established by this section.

§ 3. This act shall take effect immediately.

PART TT

Section 1. Section 26 of part B of chapter 59 of the laws of 2016, section 8 of part C of chapter 57 of the laws of 2018, sections 11, 12, 20 and 21 of part MM of chapter 56 of the laws of 2020 shall be of no force or effect on or after the effective date of this section.

§ 2. This act shall take effect immediately.

PART UU

Section 1. Subdivision (a) of section 25.03 of the mental hygiene law, as amended by section 4 of part G of chapter 56 of the laws of 2013, is amended to read as follows:

(a) In accordance with the provisions of this article, and within appropriations made available, the office may provide state aid to a program operated by a local governmental unit or voluntary agency [~~up to one hundred per centum of the approved net operating costs of such program~~] **based on a payment for services model developed by the office, in consultation with operators of funded programs, for programs** operated by a local governmental unit or voluntary agency, and state aid may also be granted to a program operated by a local governmental unit or a voluntary agency for capital costs associated with the provision of services at a rate of up to one hundred percent of approved capital costs. Such state aid shall not be granted unless and until such program operated by a local governmental unit or voluntary agency is in compliance with all regulations promulgated by the commissioner regarding the financing of capital projects. Such state aid [~~for approved net operating costs~~] shall be made available by way of advance or reimbursement, through either contracts entered into between the office and such voluntary agency or by distribution of such state aid to local governmental units through [~~a grant~~] **the** process pursuant to section 25.11 of this article.

§ 2. Subdivisions (a) and (b) of section 25.11 of the mental hygiene law, as added by section 9 of part G of chapter 56 of the laws of 2013, are amended to read as follows:

(a) Local governmental units shall be granted state aid by a state aid funding authorization letter issued by the office [~~for approved net operating costs~~] **based on a payment for services model developed by the office, in consultation with operators of funded programs,** for voluntary agencies [~~to support the base amount of state aid provided to such voluntary agencies for the prior year~~] provided that the local governmental unit has approved and submitted budgets for the voluntary agencies to the office. The voluntary agency budgets shall identify the nature of the services to be provided which must be consistent with the local services plan submitted by the local governmental unit pursuant to article forty-one of this chapter, the areas to be served and include a description of the voluntary agency contributions and local governmental unit funding provided. The local governmental unit shall enter into contracts with the voluntary agencies receiving such state aid. Such contracts shall include funding requirements set by the office including but not limited to responsibilities of voluntary agencies relating to work scopes, program performance and operations, [~~application of program income, prohibited use of funds,~~] recordkeeping and audit obligations. Upon designation by the office, local governmental units shall notify voluntary agencies as to the source of funding received by such voluntary agencies.

(b) State aid made available to a local governmental unit [~~for approved net operating costs~~] **based on a payment for services model developed by the office, in consultation with operators of funded programs** for a program operated by a voluntary agency or a local governmental unit may be reduced where a review of such voluntary agency's prior year's budget and/or performance indicates[~~: (1)~~] that the program operated by a local governmental unit or voluntary agency has failed to meet minimum performance standards and requirements of the office including, but not limited to, maintaining service utilization rates and productivity standards as set by the office provided however,

that upon determination that the program is not meeting the minimum standards and requirements, the office shall notify such program operated by a local governmental unit or voluntary agency of their deficiencies, and if appropriate, a corrective action plan that includes specific actions to address any deficiencies and a timetable for implementation shall be developed. State aid may be reduced if a corrective action plan is not approved by the office or is not implemented in a timely and satisfactory manner[~~;~~

~~(2) that the voluntary agency has had an increase in voluntary agency contributions that reduces the approved net operating costs necessary, except where the office has approved an alternative use of such voluntary agency contributions or such voluntary agency contributions are necessary to ensure financial viability~~].

§ 3. This act shall take effect January 1, 2023 and shall apply to program budgets developed on or after such date.

PART VV

Section 1. Subdivisions 2 and 2-a of section 1.03 of the mental hygiene law, subdivision 2 as amended and subdivision 2-a as added by chapter 281 of the laws of 2019, are amended to read as follows:

2. [~~"Commissioner" means the commissioner of mental health,~~] **"Commissioner" means the commissioner of addiction and mental health services and** the commissioner of developmental disabilities [~~and the commissioner of addiction services and supports~~] as used in this chapter. Any power or duty heretofore assigned to the commissioner of mental hygiene or to the department of mental hygiene pursuant to this chapter shall hereafter be assigned to the commissioner of [~~mental health~~] **addiction and mental health services** in the case of facilities, programs, or services for individuals with [~~mental illness~~] **a mental health diagnosis**, to the commissioner of developmental disabilities in the case of facilities, programs, or services for individuals with developmental disabilities, to the commissioner of addiction [~~services~~] and [~~supports~~] **mental health services** in the case of facilities, programs, or addiction disorder services in accordance with the provisions of titles D and E of this chapter.

2-a. Notwithstanding any other section of law or regulation, on and after the effective date of this subdivision, any and all references to the office of alcoholism and substance abuse services and the predecessor agencies to the office of alcoholism and substance abuse services including the division of alcoholism and alcohol abuse and the division of substance abuse services **and all references to the office of mental health**, shall be known as the "office of addiction [~~services~~] and [~~supports~~] **mental health services**." Nothing in this subdivision shall be construed as requiring or prohibiting the further amendment of statutes or regulations to conform to the provisions of this subdivision.

§ 2. Section 5.01 of the mental hygiene law, as amended by chapter 281 of the laws of 2019, is amended and two new sections 5.01-a and 5.01-b are added to read as follows:

§ 5.01 Department of mental hygiene.

There shall continue to be in the state government a department of mental hygiene. Within the department there shall be the following autonomous offices:

(1) office of **addiction and** mental health **services**; **and**

(2) office for people with developmental disabilities[~~;~~

~~(3) office of addiction services and supports~~].

§ 5.01-a Office of addiction and mental health services.

(a) The office of addiction and mental health services shall be a new office within the department formed by the integration of the offices and services of mental health and addiction services and supports which shall focus on the integration of care and issues related to both mental illness and addiction in the state and carry out the intent of the legislature in establishing the offices pursuant to articles seven and nineteen of this chapter. The office of addiction and mental health services is charged with ensuring the development of comprehensive plans for the integration of programs and services in the area of research, prevention, care and treatment, co-occuring disorders, rehabilitation, education and training, and shall be staffed to perform the responsibilities attributed to the office pursuant to sections 7.07 and 19.07 of this chapter and provide integrated services and programs to promote recovery for individuals with a mental health diagnosis, substance use disorder, or a mental health diagnosis and substance use disorder.

(b) The commissioner of the office of addiction and mental health services shall be vested with the powers, duties, and obligations of the office of mental health and the office of addiction services and supports. Additionally, two deputy commissioners shall be appointed, one deputy commissioner to represent addiction services and supports, which shall be prominently represented to ensure the needs of substance use disorder communities are met, and one deputy commissioner to represent mental health services. In conjunction with one another, the commissioners shall develop a plan for integrating services which shall be made available for public comment.

(c) The office of addiction and mental health services may license providers to provide integrated services for individuals with a mental health diagnosis, substance use disorder, or a mental health diagnosis and substance use disorder, in accordance with regulations issued by the commissioner. Such direct licensing mechanism allows for resources to get to community-based organizations in an expedited manner.

(d) The office of addiction and mental health services shall establish a standing advisory committee on addiction and mental health services. The standing advisory committee shall consist of seven members appointed by the governor as follows: (i) two members appointed on the recommendation of the temporary president of the senate; (ii) two members appointed on the recommendation of the speaker of the assembly; (iii) one member appointed on the recommendation of the minority leader of the senate; (iv) one member appointed on the recommendation of the minority leader of the assembly; and (v) one member appointed on the recommendation of the department of health AIDS institute, the office of mental health and the office of addiction services and supports to ensure the intent of the legislature is fulfilled in establishing the integration of services by such office. Such standing advisory committee shall consist of providers, peers, family members, individuals who have utilized addiction services and supports and/or mental health services, the local government unit as defined in article forty-one of this chapter, public and private sector unions and representatives of other agencies or offices as the designated standing advisory committee may deem necessary. Such standing advisory committee shall meet regularly in furtherance of its functions and at any other time at the request of the designated standing advisory committee leader.

§ 5.01-b Office of addiction and mental health services.

Until January first, two thousand twenty-three, the office of addiction and mental health services shall consist of the office of mental health and the office of addiction services and supports.

§ 3. Section 5.03 of the mental hygiene law, as amended by chapter 281 of the laws of 2019, is amended to read as follows:

§ 5.03 Commissioners.

The head of the office of **addiction and** mental health **services** shall be the commissioner of [~~mental health~~] **addiction and mental health services**; **and** the head of the office for people with developmental disabilities shall be the commissioner of developmental disabilities[~~; and the head of the office of addiction services and supports shall be the commissioner of addiction services and supports~~]. Each commissioner shall be appointed by the governor, by and with the advice and consent of the senate, to serve at the pleasure of the governor. **Until the commissioner of addiction and mental health services is appointed by the governor and confirmed by the senate, the commissioner of mental health and the commissioner of addiction services and supports shall continue to oversee mental health and addiction services respectively, and work collaboratively to integrate care for individuals with both mental health and substance use disorders.**

§ 4. Section 5.05 of the mental hygiene law, as added by chapter 978 of the laws of 1977, subdivision (a) as amended by chapter 168 of the laws of 2010, subdivision (b) as amended by chapter 294 of the laws of 2007, paragraph 1 of subdivision (b) as amended by section 14 of part J of chapter 56 of the laws of 2012, subdivision (d) as added by chapter 58 of the laws of 1988 and subdivision (e) as added by chapter 588 of the laws of 2011, is amended to read as follows:

§ 5.05 Powers and duties of the head of the department.

(a) The commissioners of the office of **addiction and** mental health **services** and the office for people with developmental disabilities, as the heads of the department, shall jointly visit and inspect, or cause to be visited and inspected, all facilities either public or private used for the care, treatment [~~and~~]**,** rehabilitation**, and recovery** of individuals with **a** mental [~~illness~~] **health diagnosis, substance use disorder** and developmental disabilities in accordance with the requirements of section four of article seventeen of the New York state constitution.

(b) (1) The commissioners of the office of **addiction and** mental health[~~,~~] **services and** the office for people with developmental disabilities [~~and the office of alcoholism and substance abuse services~~] shall constitute an inter-office coordinating council which, consistent with the autonomy of each office for matters within its jurisdiction, shall ensure that the state policy for the prevention, care, treatment [~~and~~]**,** rehabilitation**, and recovery** of individuals with **a** mental [~~illness~~] **health diagnosis, substance use disorders** and developmental disabilities[~~, alcoholism, alcohol abuse, substance abuse, substance dependence, and chemical dependence~~] is planned, developed and implemented comprehensively; that gaps in services to individuals with multiple disabilities are eliminated and that no person is denied treatment and services because he or she has more than one disability; that procedures for the regulation of programs which offer care and treatment for more than one class of persons with mental disabilities be coordinated between the offices having jurisdiction over such programs; and that research projects of the institutes, as identified in section 7.17 [~~or~~]**,** 13.17**, or 19.17** of this chapter or as operated by the office for people with developmental disabilities, are coordinated to maximize the success and

cost effectiveness of such projects and to eliminate wasteful duplication.

(2) The inter-office coordinating council shall annually issue a report on its activities to the legislature on or before December thirty-first. Such annual report shall include, but not be limited to, the following information: proper treatment models and programs for persons with multiple disabilities and suggested improvements to such models and programs; research projects of the institutes and their coordination with each other; collaborations and joint initiatives undertaken by the offices of the department; consolidation of regulations of each of the offices of the department to reduce regulatory inconsistencies between the offices; inter-office or office activities related to workforce training and development; data on the prevalence, availability of resources and service utilization by persons with multiple disabilities; eligibility standards of each office of the department affecting clients suffering from multiple disabilities, and eligibility standards under which a client is determined to be an office's primary responsibility; agreements or arrangements on statewide, regional and local government levels addressing how determinations over client responsibility are made and client responsibility disputes are resolved; information on any specific cohort of clients with multiple disabilities for which substantial barriers in accessing or receiving appropriate care has been reported or is known to the inter-office coordinating council or the offices of the department; and coordination of planning, standards or services for persons with multiple disabilities between the inter-office coordinating council, the offices of the department and local governments in accordance with the local planning requirements set forth in article forty-one of this chapter.

(c) The commissioners shall meet from time to time with the New York state conference of local mental hygiene directors to assure consistent procedures in fulfilling the responsibilities required by this section and by article forty-one of this chapter.

(d) [~~1.~~] **(1)** The commissioner of **addiction and** mental health **services** shall evaluate the type and level of care required by patients in the adult psychiatric centers authorized by section 7.17 of this chapter and develop appropriate comprehensive requirements for the staffing of inpatient wards. These requirements should reflect measurable need for administrative and direct care staff including physicians, nurses and other clinical staff, direct and related support and other support staff, established on the basis of sound clinical judgment. The staffing requirements shall include but not be limited to the following: (i) the level of care based on patient needs, including on ward activities, (ii) the number of admissions, (iii) the geographic location of each facility, (iv) the physical layout of the campus, and (v) the physical design of patient care wards.

[~~2.~~] **(2)** Such commissioner, in developing the requirements, shall provide for adequate ward coverage on all shifts taking into account the number of individuals expected to be off the ward due to sick leave, workers' compensation, mandated training and all other off ward leaves.

[~~3.~~] **(3)** The staffing requirements shall be designed to reflect the legitimate needs of facilities so as to ensure full accreditation and certification by appropriate regulatory bodies. The requirements shall reflect appropriate industry standards. The staffing requirements shall be fully measurable.

[~~4.~~] **(4)** The commissioner of **addiction and** mental health **services** shall submit an interim report to the governor and the legislature on

the development of the staffing requirements on October first, [~~nineteen hundred eighty-eight~~] two thousand twenty-two and again on April first, [~~nineteen hundred eighty-nine~~] two thousand twenty-three. The commissioner shall submit a final report to the governor and the legislature no later than October first, [~~nineteen hundred eighty-nine~~] two thousand twenty-three and shall include in his report a plan to achieve the staffing requirements and the length of time necessary to meet these requirements.

(e) The commissioners of the office of addiction and mental health[~~,~~] services and the office for people with developmental disabilities[~~, and the office of alcoholism and substance abuse services~~] shall cause to have all new contracts with agencies and providers licensed by the offices to have a clause requiring notice be provided to all current and new employees of such agencies and providers stating that all instances of abuse shall be investigated pursuant to this chapter, and, if an employee leaves employment prior to the conclusion of a pending abuse investigation, the investigation shall continue. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract.

§ 5. Section 7.01 of the mental hygiene law, as added by chapter 978 of the laws of 1977, is amended to read as follows:

§ 7.01 Declaration of policy.

The state of New York and its local governments have a responsibility for the prevention and early detection of mental [~~illness~~] health disorders and for the comprehensively planned care, treatment [~~and~~], rehabilitation and recovery of [~~their mentally ill citizens~~] individuals with a mental health diagnosis.

Therefore, it shall be the policy of the state to conduct research and to develop programs which further prevention and early detection of mental [~~illness~~] health disorders; to develop a comprehensive, integrated system of treatment [~~and~~], rehabilitative and recovery services for [~~the mentally ill~~] individuals with a mental health diagnosis. Such a system should include, whenever possible, the provision of necessary treatment services to people in their home communities; it should assure the adequacy and appropriateness of residential arrangements for people in need of service; and it should rely upon improved programs of institutional care only when necessary and appropriate. Further, such a system should recognize the important therapeutic roles of all disciplines which may contribute to the care or treatment of [~~the mentally ill~~] individuals with a mental health diagnosis, such as psychology, social work, psychiatric nursing, special education and other disciplines in the field of mental illness, as well as psychiatry and should establish accountability for implementation of the policies of the state with regard to the care [~~and~~], rehabilitation and recovery of [~~the mentally ill~~] individuals with a mental health diagnosis.

To facilitate the implementation of these policies and to further advance the interests of [~~the mentally ill~~] individuals with a mental health diagnosis and their families, a new autonomous agency to be known as the office of addiction and mental health services has been established by this article. The office and its commissioner shall plan and work with local governments, voluntary agencies and all providers and consumers of mental health services in order to develop an effective, integrated, comprehensive system for the delivery of all services to [~~the mentally ill~~] individuals with a mental health diagnosis and to create financing procedures and mechanisms to support such a system of

services to ensure that [~~mentally ill~~] persons in need of services receive appropriate care, treatment and rehabilitation close to their families and communities. In carrying out these responsibilities, the office and its commissioner shall make full use of existing services in the community including those provided by voluntary organizations.

§ 6. Section 19.01 of the mental hygiene law, as added by chapter 223 of the laws of 1992, is amended to read as follows:

§ 19.01 Declaration of policy.

The legislature declares the following:

[~~Alcoholism~~] **Unhealthy alcohol use**, substance [~~abuse~~] **use disorder** and chemical dependence pose major health and social problems for individuals and their families when left untreated, including family devastation, homelessness, [~~and~~] unemployment**, and death**. It has been proven that successful prevention [~~and~~]**, integrated** treatment**, and sustained recovery** can dramatically reduce costs to the health care, criminal justice and social welfare systems.

The tragic, cumulative and often fatal consequences of [~~alcoholism~~] **unhealthy alcohol use** and substance [~~abuse~~] **use disorder** are, however, preventable and treatable disabilities that require a coordinated and multi-faceted network of services.

The legislature recognizes locally planned and implemented prevention as a primary means to avert the onset of [~~alcoholism~~] **unhealthy alcohol use** and substance [~~abuse~~] **use disorder**. It is the policy of the state to promote comprehensive, age appropriate education for children and youth and stimulate public awareness of the risks associated with [~~alcoholism~~] **unhealthy alcohol use** and substance [~~abuse~~] **use disorder**. Further, the legislature acknowledges the need for a coordinated state policy for the establishment of prevention [~~and~~]**,** treatment**, and recovery** programs designed to address the problems of chemical dependency among youth, including prevention and intervention efforts in school and community-based programs designed to identify and refer high risk youth in need of chemical dependency services.

Substantial benefits can be gained through [~~alcoholism~~] **unhealthy alcohol use** and substance [~~abuse~~] **use disorder** treatment for both addicted individuals and their families. Positive treatment outcomes that may be generated through a complete continuum of care offer a cost effective and comprehensive approach to [~~rehabilitating~~] **treating** such individuals. The primary goals of the [~~rehabilitation~~] **treatment** and recovery process are to [~~restore~~] **rebuild** social, family, lifestyle, vocational and economic supports by stabilizing an individual's physical and psychological functioning. The legislature recognizes the importance of varying treatment approaches and levels of care designed to meet each [~~client's~~] **individual's** needs. [~~Relapse~~] **Reoccurrence** prevention and aftercare are two primary components of treatment that serve to promote and maintain recovery.

The legislature recognizes that the distinct treatment needs of special populations, including women and women with children, persons with HIV infection, persons [~~diagnosed~~] with **a** mental [~~illness~~] **health diagnosis**, persons who [~~abuse~~] **misuse** chemicals, the homeless and veterans with posttraumatic stress disorder, merit particular attention. It is the intent of the legislature to promote effective interventions for such populations in need of particular attention. The legislature also recognizes the importance of family support for individuals in alcohol or substance [~~abuse~~] **use disorder** treatment and recovery. Such family participation can provide lasting support to the recovering individual to [~~prevent relapse and maintain~~] **support sustained** recovery. The inter-

generational cycle of chemical dependency within families can be intercepted through appropriate interventions.

The state of New York and its local governments have a responsibility in coordinating the delivery of [~~alcoholism~~] unhealthy alcohol use and substance [~~abuse~~] use disorder services, through the entire network of service providers. To accomplish these objectives, the legislature declares that the establishment of a single, unified office of [~~alcoholism and substance abuse~~] addiction and mental health services will provide an integrated framework to plan, oversee and regulate the state's prevention and treatment network. In recognition of the growing trends and incidence of chemical dependency, this consolidation allows the state to respond to the changing profile of chemical dependency. The legislature recognizes that some distinctions exist between the [~~alcoholism~~] unhealthy alcohol use and substance [~~abuse~~] use disorder field and the mental health field and where appropriate, those distinctions may be preserved. Accordingly, it is the intent of the state to establish one office of [~~alcoholism and substance abuse~~] addiction and mental health services in furtherance of a comprehensive service delivery system.

§ 7. Upon or prior to January 1, 2023, the governor may nominate an individual to serve as commissioner of the office of addiction and mental health services. If such individual is confirmed by the senate prior to January 1, 2023, they shall become the commissioner of the office of addiction and mental health services. The governor may designate a person to exercise the powers of the commissioner of the office of addiction and mental health services on an acting basis, until confirmation of a nominee by the senate, who is hereby authorized to take such actions as are necessary and proper to implement the orderly transition of the functions, powers as duties as herein provided, including the preparation for a budget request for the office as established by this act.

§ 8. Upon the transfer pursuant to this act of the functions and powers possessed by and all of the obligations and duties of the office of mental health and the office of addiction services and supports as established pursuant to the mental hygiene law and other laws, to the office of addiction and mental health services as prescribed by this act, provision shall be made for the transfer of all employees from the office of mental health and the office of addiction services and supports into the office of addiction and mental health services. Employees so transferred shall be transferred without further examination or qualification to the same or similar titles and shall remain in the same collective bargaining units and shall retain their respective civil service classifications, status, and rights pursuant to their collective bargaining units and collective bargaining agreements.

§ 9. Notwithstanding any contrary provision of law, on or before October 1, 2022 and annually thereafter, the office of addiction and mental health services, in consultation with the department of health, shall issue a report, and post such report on their public website, detailing the office's expenditures for addiction and mental health services, including total Medicaid spending directly by the state to licensed or designated providers and payments to managed care providers pursuant to section 364-j of the social services law. The office of addiction and mental health services shall examine reports produced pursuant to this section and may make recommendations to the governor and the legislature regarding appropriations for addiction and mental health services or

other provisions of law which may be necessary to effectively implement the creation and continued operation of the office.

§ 10. Any financial saving realized from the creation of the office of addiction and mental health services shall be reinvested in the services and supports funded by such office.

§ 11. Severability. If any clause, sentence, paragraph, 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, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

§ 12. This act shall take effect April 1, 2023. Effective immediately, the office of mental health and the office of addiction services and supports are authorized to promulgate the addition, amendment and/or repeal of any rule or regulation or engage in any work 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 WW

Section 1. The mental hygiene law is amended by adding two new sections 7.51 and 7.53 to read as follows:

§ 7.51 Crisis intervention demonstration program.

(a) The commissioner shall establish a crisis intervention demonstration program in the state of New York for the purpose of assisting law enforcement officers in responding to crisis situations involving persons with mental illness and/or substance use disorder.

(b) The commissioner shall establish within the office the position of crisis intervention team training program coordinator who will serve at the pleasure of the commissioner and who shall work with municipal police departments and any other law enforcement agency in the state that requests assistance to coordinate the provision of crisis intervention team training to its first responders as a part of a specialized response team or as part of training for first responders.

(c) The crisis intervention team training program coordinator shall:

(1) work with communities to develop partnerships, coordinate activities and promote cooperation and collaboration between the office, the office of alcoholism and substance abuse services, law enforcement agencies, disability service providers and people with psychiatric or other disabilities and their families to provide crisis intervention team training;

(2) provide coordination activities and funding support for crisis intervention team training;

(3) provide support, training and community coordination to ensure that mental health service providers in the community provide alternatives to incarceration;

(4) provide funding to support training and community coordination costs as necessary. All moneys shall be deposited in the crisis intervention team training fund established by section ninety-nine-pp of the state finance law;

(5) in consultation with the crisis intervention advisory committee established by this article, distribute crisis intervention team training fund moneys as needed for support, training and community coordination costs; and

(6) submit a report to the governor, temporary president of the senate, speaker of the assembly and the crisis intervention advisory

committee on or before November fifteenth of each year that contains the following:

(A) a review of all law enforcement agencies that have provided crisis intervention team training to their officers and the number of officers that have completed the training;

(B) a list of communities in this state that have implemented the crisis intervention team training program through training and coordination, including the length of implementation and current status of the program;

(C) recommendations for improvement in the community based partnerships that support crisis intervention team responses;

(D) recommendations for improvement in the law enforcement and public safety agencies that provide crisis intervention team responses; and

(E) a review of all funding resources that the crisis intervention team training program coordinator has applied for to increase available funding, including the status of all funding requests and the total of moneys received.

(d) The demonstration program established pursuant to this section shall end five years after the effective date of this section.

§ 7.53 Crisis intervention advisory committee.

(a) There is hereby established a crisis intervention advisory committee.

(b) The committee shall consist of:

(1) The commissioner, who shall serve as chairperson of the committee and who is a nonvoting member;

(2) the crisis intervention team training program coordinator, who is a nonvoting member;

(3) one member appointed by the commissioner who is a consumer of mental health services;

(4) one member appointed by the commissioner who is an immediate family member of a consumer of mental health services;

(5) one member appointed by the commissioner who represents a statewide advocacy agency that serves persons with mental disabilities and their families;

(6) one member appointed by the commissioner who is a psychiatrist or psychologist licensed in the state;

(7) one member appointed by the commissioner of addiction services and supports;

(8) one member appointed by the commissioner of addiction services and supports who represents a statewide behavior advocacy group, agency or association;

(9) one member appointed by the commissioner of the office for people with developmental disabilities who is either a family member or guardian of a person with a developmental disability;

(10) one member appointed by the commissioner of the office for people with developmental disabilities who is a person with a developmental disability;

(11) one member appointed by the commissioner of the division of criminal justice services upon the recommendation of a state benevolent association representing peace officers who is a certified peace officer;

(12) one member appointed by the commissioner of the division of criminal justice services who is a law enforcement officer; and

(13) one member of a police department appointed by each county that has a crisis intervention team established pursuant to section two hundred nine-ggg of the general municipal law.

(c) The committee shall:

(1) meet at least two times in each full calendar year. The committee shall meet at the request of its chairperson; and

(2) review the report required by section 7.51 of this article and based on that report make recommendations to the office of mental health, the office for people with developmental disabilities, the office of addiction services and supports, the division of criminal justice services, municipal police departments, the governor, the temporary president of the senate and the speaker of the assembly.

(d) Committee members shall not be compensated but are eligible for reimbursement of reasonable expenses.

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

§ 99-pp. Crisis intervention team training fund. 1. There is hereby established in the joint custody of the comptroller and the commissioner of the office of mental health a fund to be known as the crisis intervention team training fund.

2. The crisis intervention team training fund shall consist of all moneys received from the federal government, New York state government, and private grants.

3. Any contractors that receive moneys pursuant to this section shall submit quarterly reports to the commissioner of the office of mental health regarding the use and effectiveness of the distributed moneys. The commissioner of the office of mental health shall include a summary of the fund analysis in the annual report required pursuant to section 7.51 of the mental hygiene law.

§ 3. The general municipal law is amended by adding a new section 209-ggg to read as follows:

§ 209-ggg. Crisis intervention teams. 1. The commissioner of the division of criminal justice services, in consultation with the commissioners of the office of mental health, office for people with developmental disabilities and the office of addiction services and supports, shall, for all local police departments and any other enforcement agency that chooses to participate:

(a) establish criteria for the development of crisis intervention teams; and

(b) establish, and implement on an ongoing basis, a training program for all current and new employees regarding the policies and procedures established pursuant to this section. The curriculum shall include a minimum of forty hours of mandatory training in mental health issues.

2. The goals of the crisis intervention team program shall be to:

(a) provide immediate response by specifically trained law enforcement officers;

(b) reduce the amount of time police officers spend out of service awaiting assessment and disposition;

(c) afford persons with mental illness and/or substance use disorder a sense of dignity in crisis situations;

(d) reduce the likelihood of physical confrontation;

(e) identify underserved populations with mental illness and/or substance use disorder and refer them to appropriate care;

(f) decrease the use of arrest and detention of persons experiencing mental health and/or substance use crises by providing better access to timely treatment;

(g) provide therapeutic locations or protocols for officers to bring individuals in crisis for assessment that is not a law enforcement or jail facility; and

(h) decrease injuries to law enforcement officers during crisis events.

3. Other state agencies shall provide cooperation and assistance to the division of criminal justice services to assist in the effective performance of its duties.

§ 4. Section 19.07 of the mental hygiene law is amended by adding a new subdivision (o) to read as follows:

(o) The office of addiction services and supports shall, in collaboration with law enforcement and the office of mental health, establish criteria for the development of crisis intervention teams that shall include assessment of the effectiveness of the plan for community involvement, training and therapeutic response alternatives and a determination of whether law enforcement officers have effective agreements with mental health care providers and all other community stakeholders.

§ 5. This act shall take effect immediately.

PART XX

Section 1. Legislative intent. During the pandemic, New York's seniors, and disabled individuals, particularly those residing in nursing homes and long-term care facilities, were at the most significant risk of contracting and dying from the coronavirus. The families of these vulnerable individuals were faced with the life and death decision to allow their loved ones to remain in a congregate facility where they would have limited access, ensuring sufficient safety and care, or bring them home and provide all care for their loved ones themselves. The health and safety risks associated with living in a congregate setting during the pandemic proved too great for many, resulting in families opting to bring their aging and disabled family members home. Keeping our most vulnerable in the home often required drastic changes to long-term care plans and brought new challenges for families trying to ensure the safety and health of their loved ones. Providing for these family members at home often required finding assistance to adequately care for these vulnerable individuals, increasing demand for home care providers. New York has a documented shortage of home care workforce, so families trying to find a caregiver whom they trusted to enter their home during this critical time for their at-risk family member became highly challenging and at times impossible. As a result, consumer-directed personal assistants, or family home care, became the safety net provider for the state's most vulnerable population. Having the ability to employ a trusted friend or family member to provide the care needed for our most susceptible family members became a critical resource in providing the care they needed.

Ensuring the health and safety of our seniors and disabled citizens by allowing them to remain in their own homes ought to be a priority for the state as we reassess the delivery of long-term care. Maintaining and responding to an increased need for consumer-directed home care services is more crucial than ever before and requires a full assessment of the program's needs, including the number of administrators, geographical location, wages and reimbursements, and other supports needed to ensure a continuity of care for all individuals being served.

§ 2. The commissioner of health is hereby directed to prepare a study of the Consumer Directed Personal Care Program, authorized by section 365-j of the social services law, to assess the current need and costs associated with consumer-directed services within the state, including, but not limited to, total current and anticipated eligible Medicaid

recipients; the appropriate number of fiscal intermediaries required to ensure continuity of care and program administration for all participants statewide; the need for procurement of fiscal intermediary services; all evidence-based criteria and scoring to be used during any procurement process, if required; and the need for any programmatic changes to support the program. The commissioner shall issue recommendations based on such findings.

§ 3. The commissioner of health shall provide the study to the temporary president of the senate, the speaker of the assembly, and the chairs of the senate and assembly health committees by December thirty-first, two thousand twenty-three. Until such time, all changes to the program shall be suspended, and, if necessary, a reissuance of the request for offers shall be released one hundred eighty days after the study's release. The commissioner shall also publish the study on the department of health's website within thirty days of its transmittal to the legislature.

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