# STATE OF NEW YORK

8307--B

# IN SENATE

January 17, 2024

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

AN ACT to repeal sections 91 and 92 of part H of chapter 59 of the laws of 2011 relating to the year to year rate of growth of Department of Health state funds and Medicaid funding, relating to the state Medicaid spending cap and related processes (Part A); to amend the public health law, in relation to extending certain provisions related to the issuance of accountable care organization certifications and state oversight of antitrust provisions; to amend part D of chapter 56 of the laws of 2013 amending the social services law relating to eligibility conditions, chapter 649 of the laws of 1996 amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, part V of chapter 57 of the laws of 2022 amending the public health law and the insurance law relating to reimbursement for commercial and Medicaid services provided via telehealth, in relation to the effectiveness thereof; to amend the public health law, in relation to reimbursement for telehealth services; to amend chapter 659 of the laws of 1997 amending the public health law and other laws relating to creation of continuing care retirement communities and part NN of chapter 57 of the laws of 2018 amending the public health law and the state finance law relating to enacting the opioid stewardship act, in relation to the effectiveness thereof; to amend the state finance law, in relation to the Opioid stewardship fund; to amend part II of chapter 54 of the laws of 2016 amending part C of chapter 58 of the laws of 2005 relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and administration thereof, part B of chapter 57 of the laws of 2015 amending the social services law and other laws relating to energy audits and/or disaster preparedness reviews of residential healthcare facilities by the commissioner, and part H of chapter 57 of the laws of 2019 amending the public health law relating to waiver of certain regulations, in relation to the effectiveness thereof; to

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

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amend the social services law, in relation to provision of services in school-based health centers; and to amend part Q of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the closure or transfer of a state-operated individualized residential alternative and chapter 670 of the laws of 2021 requiring the office for people with developmental disabilities to establish the care demonstration program, in relation to the effectiveness thereof (Part B); to amend chapter 217 of the laws of 2015, amending the education law relating to certified school psychologists and special education services and programs for preschool children with handicapping conditions, in relation to the effectiveness thereof (Part C); to amend part E of chapter 57 of the laws of 2015, amending the public health law relating to the payment of certain funds for uncompensated care, in relation to certain payments being made as outpatient upper payment limit payments for outpatient hospital services during certain state fiscal years and calendar years; to amend part B of chapter 57 of the laws of 2015, amending the social services law relating to supplemental rebates, in relation to authorizing the department of health to increase operating cost component of rates of payment for general hospital outpatient services and authorizing the department of health to pay a public hospital adjustment to public general hospitals during certain state fiscal years and calendar years; to amend the public health law, in relation to authorizing the commissioner to make additional inpatient hospital payments during certain state fiscal years and calendar years; and to amend part B of chapter 58 of the laws of 2010, amending the social services law and the public health law relating to prescription drug coverage for needy persons and health care initiatives pools, in relation to authorizing the department of health to make Medicaid payment increases for county operated free-standing clinics during certain state fiscal years and calendar years (Part D); to amend the public health law, in relation to eligibility for admission to the New York state veterans' home (Part E); to amend the social services law, in relation to making the special needs assisted living residence voucher program permanent; and to amend the public health law, in relation to assisted living quality improvement standards (Part F); intentionally omitted (Part G); intentionally omitted (Part H); intentionally omitted (Part I); to amend the social services law, in relation to renaming the basic health program to the essential plan, and in relation to coverage for certain individuals under the 1332 state innovation program; to amend part H of chapter 57 of the laws of 2021, amending the social services law relating to eliminating consumer-paid premium payments in the basic health program, in relation to the effectiveness thereof; and to amend part BBB of chapter 56 of the laws of 2022, amending the public health law and other laws relating to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent, in relation to extending certain provisions related to providing long-term services and supports under the essential plan; and to amend the public health law, in relation to adding references to the 1332 state innovation waiver, providing a new subsidy to assist low-income New Yorkers with the payment of premiums, cost sharing or both through the marketplace, and adding the 1332 state innovation program to the functions of the marketplace (Part J); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating

to malpractice and professional medical conduct, in relation to insurance coverage paid for by funds from the hospital excess liability pool and extending the effectiveness of certain provisions thereof; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017 amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part K); intentionally omitted (Part L); to amend the social services law and the public health law, in relation to authorizing continuous coverage in Medicaid and child health plus, for eligible children ages zero to six (Part M); to amend the public health law, in relation to authorizing the commissioner of health to issue a statewide standing order for the provision of doula services, providing medical services to pregnant minors, and to the provision of contraception (Part N); to amend the public health law, in relation to expanding financial assistance; and to amend the general business law, in relation to additional consumer protection for medical debt and restricting the applications for and use of credit cards and medical financial products (Part O); to amend part C of chapter 57 of the laws of 2022 amending the public health law and the education law relating to allowing pharmacists to direct limited service laboratories and order and administer COVID-19 and influenza tests and modernizing nurse practitioners, and chapter 21 of the laws of 2011 amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to the effectiveness thereof (Part P); intentionally omitted (Part Q); intentionally omitted (Part R); to amend the public health law, in relation to establishing the health care facility transformation program (Part S); to amend the public health law and the education law, in relation to making necessary changes to end the HIV, HCV, HBV, syphilis and mpox epidemics; and to repeal certain provisions of the public health law relating thereto (Part T); to amend the public health law, in relation to increasing prescription monitoring program data retention periods and allowing enhanced data sharing to combat the opioid crisis, and updating the term "addict" to "person with a substance use disorder" in certain provisions of such law; and to repeal section 3372 of such law relating to practitioner patient reporting (Part U); to amend the general municipal law and the public health law, in relation to emergency medical services (Part V); to amend the elder law, in relation to establishing the interagency elder justice task force; and providing for the repeal of such provisions upon expiration thereof (Part W); intentionally omitted (Part X); to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to the effectiveness thereof; and to amend the mental hygiene law, in relation to reporting on the community mental health support and workforce (Part Y); to amend the mental hygiene law, in relation to reporting on demonstration programs; and to amend part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating

to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, in relation to the effectiveness thereof (Part Z); to amend the insurance law, in relation to setting minimal reimbursement for behavioral health treatment (Part AA); to amend chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, in relation to the effectiveness of certain provisions thereof; and to amend the mental hygiene law, in relation to requiring the submission of a report on comprehensive psychiatric emergency programs (Part BB); clarifying the requirements related to referrals of substantiated reports of abuse or neglect from the justice center to the office of the Medicaid inspector general (Part CC); to amend part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part DD); intentionally omitted (Part EE); to establish a cost of living adjustment for designated human services programs (Part FF); to amend the social services law, in relation to providing contracting flexibility in relation to 1115 medicaid waivers; and providing for the repeal of such provisions upon expiration thereof (Part GG); intentionally omitted (Part HH); to amend the public health law, in relation to medically fragile young adults and pediatric specialized nursing facilities (Part II); to amend the public health law, in relation to federally qualified health center rate adequacy (Part JJ); to amend the public health law, in relation to residential health care facility rates (Part KK); to amend the public health law, in relation to decreasing the electronic death registration system fee for funeral directors and undertakers (Part LL); to amend the public health law, in relation to authorizing a prenatal and postpartum informational mobile application (Part MM); to amend the social services law, in relation to increasing the amount of the savings exemption for eligibility for Medicaid and eliminating the asset test for certain individuals; and to repeal certain provisions of such law relating thereto (Part NN); to amend the public health law, in relation to certain rates of payment for services provided by assisted living programs (Part OO); to amend the social services law, in relation to eliminating a "look-back period" for home care for non-institutionalized Medicaid applicants; and repealing certain provisions of such law relating thereto (Part PP); to amend the public health law, in relation to establishing the office of hospice and palliative care access and quality (Part QQ); to amend section 1 of part I of chapter 57 of the laws of 2022 relating to providing one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to criteria for certain Medicaid payments (Part RR); to amend the mental hygiene law, in relation to providing mental telehealth services to children, adolescents, and young adults (Part SS); to amend the public health law, in relation to enacting the reproductive freedom and equity grant program (Part TT); relating to establishing a direct support wage enhancement to employees that provide direct care support or any other form of treatment, to individuals with developmental disabilities (Part UU); to amend the public health law, in relation to doula friendly work spaces (Part VV); to amend the public health law, in relation to the creation of a community doula expansion grant program; and to amend the state finance law, in relation to the community doula expansion grant

program fund (Part WW); to amend the public health law and the tax law, in relation to establishing a pilot hospital medical debt relief program (Part XX); to amend the social services law, in relation to increasing personal needs allowance amounts (Part YY); to amend the mental hygiene law, in relation to establishing a drug checking services program (Part ZZ); and to amend the public health law and the social services law, in relation to the functions of the Medicaid inspector general with respect to audit and review of medical assistance program funds and requiring notice of certain investigations (Part AAA)

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

Section 1. This act enacts into law major components of legislation necessary to implement the state health and mental hygiene budget for the 2024-2025 state fiscal year. Each component is wholly contained within a Part identified as Parts A through AAA. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

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

§ 2. This act shall take effect immediately.

PART B

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

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

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

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided, however, that sections one, two and three of this act shall expire and be deemed repealed [~~on~~] March 31, [~~2025~~] **2030** provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public

health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000.

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

3. The commissioner may issue a certificate of authority to an entity that meets conditions for ACO certification as set forth in regulations made by the commissioner pursuant to section twenty-nine hundred ninety-nine-q of this article. The commissioner shall not issue any new certificate under this article after December thirty-first, two thousand [~~twenty-four~~] twenty-eight.

§ 4. Subdivision 1 of section 2999-aa of the public health law, as amended by section 9 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

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

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

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

§ 5-a. Subdivision 1 of section 2999-dd of the public health law, as amended by section 2 of part V of chapter 57 of the laws of 2022, is amended to read as follows:

1. Health care services delivered by means of telehealth shall be entitled to reimbursement under section three hundred sixty-seven-u of the social services law on the same basis, at the same rate, and to the same extent the equivalent services, as may be defined in regulations promulgated by the commissioner, are reimbursed when delivered in

person; provided, however, that health care services delivered by means of telehealth shall not require reimbursement to a telehealth provider for certain costs, including but not limited to facility fees or costs reimbursed through ambulatory patient groups or other clinic reimbursement methodologies set forth in section twenty-eight hundred seven of this chapter, if such costs were not incurred in the provision of telehealth services due to neither the originating site nor the distant site occurring within a facility or other clinic setting; and further provided, however, reimbursement for additional modalities, provider categories and originating sites specified in accordance with section twenty-nine hundred ninety-nine-ee of this article, and audio-only telephone communication defined in regulations promulgated pursuant to subdivision four of section twenty-nine hundred ninety-nine-cc of this article, shall be contingent upon federal financial participation. Notwithstanding the provisions of this subdivision, for services licensed, certified or otherwise authorized pursuant to article sixteen, article thirty-one or article thirty-two of the mental hygiene law, **and for any services delivered through a facility licensed under article twenty-eight of this chapter that is eligible to be designated or has received a designation as a federally qualified health center in accordance with 42 USC § 1396a(aa), as amended, or any successor law thereto, including those facilities that are also licensed under article thirty-one or article thirty-two of the mental hygiene law,** such services provided by telehealth[~~, as deemed appropriate by the relevant commissioner,~~] shall be reimbursed at the applicable in person rates or fees established by law, or otherwise established or certified by the office for people with developmental disabilities, office of mental health, or the office of addiction services and supports pursuant to article forty-three of the mental hygiene law.

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

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

§ 7. Section 5 of part NN of chapter 57 of the laws of 2018 amending the public health law and the state finance law relating to enacting the opioid stewardship act, as amended by section 5 of part XX of chapter 59 of the laws of 2019, is amended to read as follows:

§ 5. This act shall take effect July 1, 2018 [~~and shall expire and be deemed to be repealed on June 30, 2024~~], provided that, effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date,

and, provided that this act shall only apply to the sale or distribution of opioids in the state of New York on or before December 31, 2018.

§ 7-a. Subdivision 4 of section 97-aaaaa of the state finance law, as added by section 3 of part NN of chapter 57 of the laws of 2018, is amended and a new subdivision 8 is added to read as follows:

4. Moneys of the opioid stewardship fund, when allocated, shall be available, subject to the approval of the director of the budget, to support programs operated by the New York state office of [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports or agencies certified, authorized, approved or otherwise funded by the New York state office of [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports to provide opioid treatment, recovery and prevention and education services; and to provide support for the prescription monitoring program registry as established pursuant to section thirty-three hundred forty-three-a of the public health law, provided, however, that at least ten percent of funds shall be invested in recovery services and supports. Provided, further, that moneys of the fund shall be used to supplement and not supplant or replace any other funds, including federal or state funding, which would otherwise have been expended for substance use disorder prevention, treatment, recovery or harm reduction services or programs.

8. (a) On or before November first of each year, beginning one year after the effective date of this subdivision, the commissioner of the office of addiction services and supports shall provide a written report to the governor, temporary president of the senate, speaker of the assembly, chair of the senate finance committee, chair of the assembly ways and means committee, chair of the senate alcoholism and substance use disorders committee, and chair of the assembly alcoholism and drug abuse committee.

(b) Such report shall be presented as a consolidated dashboard and be made publicly available on the office of addiction services and supports' website. Such report shall, to the extent practicable after making all diligent efforts to obtain such information, include the following:

(i) the baseline funding for any entity that receives funding from the opioid stewardship fund, prior to the receipt of such funds; and

(ii) how funds deposited in the opioid stewardship fund have been utilized in the preceding calendar year, including but not limited to:

(A) the amount of money disbursed from the fund and the award process used for such disbursement, if applicable;

(B) the names of the recipients, the amounts awarded to such recipient and details about the purpose such funds were awarded for, including what specific services and programs the funds were used for and what populations such services or programs served;

(C) the main criteria utilized to determine the award, including how the program or service assists efforts to reduce the effects of substance use disorders;

(D) an analysis of the effectiveness of the services and/or programs that received opioid stewardship funding in their efforts to reduce the effects of the overdose and substance use disorder epidemic. Such analysis shall utilize evidence-based uniform metrics when reviewing the effects that the service and/or program had on prevention, harm reduction, treatment, and recovery advancements;

(E) any relevant information provided by any state agency; and

**(F) any other information the commissioner deems necessary to help inform future appropriations and funding decisions, and ensure such funding is not being used to supplant local, state, or federal funding.**

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

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

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

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

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

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

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

**(d-3) Services provided in school-based health centers shall not be provided to medical assistance recipients through managed care programs established pursuant to this section and shall continue to be provided outside of managed care programs.**

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

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

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

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

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

PART C

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Section 3 of chapter 217 of the laws of 2015, amending the education law relating to certified school psychologists and special education services and programs for preschool children with handicapping

conditions, as amended by chapter 339 of the laws of 2022, is amended to read as follows:

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

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

PART D

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

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

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

health law and this section to the total of all payment amounts for such eligible hospitals. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible general hospitals other than major public general hospitals. The distribution of such payments shall be pursuant to a methodology approved by the commissioner of health in regulation.

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

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

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

Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for [~~the period~~] **each state fiscal year from** July first, two thousand ten through [~~March thirty-first, two thousand eleven,~~] **December thirty-first, two thousand twenty-four;** and [~~each state fiscal year period~~] **for the calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five; and for each calendar year** thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven, three hundred fourteen million dollars for each state fiscal year beginning April first, two thousand eleven, through March thirty-first, two thousand thirteen, and no less

than three hundred thirty-nine million dollars for each state fiscal year [~~thereafter~~] **until December thirty-first, two thousand twenty-four; and no less than three hundred thirty-nine million dollars from calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five; and for each calendar year thereafter**, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

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

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

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

1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal

financial participation, effective for [~~the period~~] each state fiscal year from August 1, 2010 through [~~March 31, 2011, and each state fiscal year~~] December 31, 2024; and for the calendar year from January 1, 2025 through December 31, 2025; and for each calendar year thereafter, the department of health is authorized to make Medicaid payment increases for diagnostic and treatment centers (DTC) services issued pursuant to section 2807 of the public health law for public DTCs operated by the New York City Health and Hospitals Corporation, at the election of the social services district in which an eligible DTC is physically located, of up to twelve million six hundred thousand dollars on an annualized basis for DTC services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on each such DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

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

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

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

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated

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

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

## PART E

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

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

(h) in the Persian Gulf conflict from the second day of August, nineteen hundred ninety to the end of such conflict including military service in Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn or Operation Inherent Resolve and was the recipient of the global war on terrorism expeditionary medal or the Iraq campaign medal

or the Afghanistan campaign medal; and who was a resident of the state of New York at the time of entry upon such active duty or who shall have been a resident of this state for [~~one year~~] six months next preceding the application for admission shall be entitled to admission to said home after the approval of the application by the board of visitors, subject to the provisions of this article and to the conditions, limitations and penalties prescribed by the regulations of the department. Any such veteran or dependent, who otherwise fulfills the requirements set forth in this section, may be admitted directly to the skilled nursing facility or the health related facility provided such veteran or dependent is certified by a physician designated or approved by the department to require the type of care provided by such facilities.

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

PART F

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

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

§ 2. Subdivisions 7 and 8 of section 4656 of the public health law, as added by chapter 2 of the laws of 2004, are renumbered subdivisions 8 and 9 and a new subdivision 7 is added to read as follows:

7. (a) All assisted living residences, as defined in subdivision one of section forty-six hundred fifty-one of this article, including those licensed and certified as an assisted living residence, special needs assisted living residence, or enhanced assisted living residence, shall:

(i) report annually on quality measures to be established by the department, in the form and format prescribed by the department, with the first report due no later than January thirty-first, two thousand twenty-five; and

(ii) post the monthly service rate, staffing complement, approved admission or residency agreement, and a consumer-friendly summary of all service fees in a conspicuous place on the facility's website and in a public space within the facility. Such information shall be made available to the public on forms developed by the department. Beginning on January first, two thousand twenty-five, this information shall also be reported to the department.

(b) The department shall score the results of the assisted living quality reporting obtained pursuant to paragraph (a) of this subdivision. Top scoring facilities shall be granted the classification of advanced standing on their annual surveillance schedules.

(i) All facilities shall be surveyed on an unannounced basis no less than annually; provided, however, that this shall not apply to surveys, inspections or investigations based on complaints received by the department under any other provision of law.

(ii) Facilities may remain on advanced standing classification provided they meet the scoring requirements in the assisted living quality reporting.

(c) Effective January thirty-first, two thousand twenty-five, the department may post on its website the results of the assisted living quality reporting collected pursuant to subparagraph (i) of paragraph (a) of this subdivision.

§ 3. Intentionally omitted.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, the provisions of section two of this act shall take effect on the one hundred twentieth day after it shall have become a law.

PART G

Intentionally Omitted

PART H

Intentionally Omitted

PART I

Intentionally Omitted

PART J

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

[~~BASIC HEALTH PROGRAM~~] ESSENTIAL PLAN

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

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

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

(b) section four of this act shall expire and be deemed repealed December 31, [~~2024~~] 2025; provided, however, the amendments to paragraph

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

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

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

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

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

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

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

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

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

(i) An initial determination of eligibility, including:

(A) eligibility to enroll in a qualified health plan;
(B) eligibility for Medicaid;
(C) eligibility for Child Health Plus;
(D) eligibility for the Basic Health Program;
(E) **eligibility for the 1332 state innovation program;**
**(F)** the amount of advance payments of the premium tax credit and level of cost-sharing reductions;
[~~(F)~~] **(G)** the amount of any other subsidy that may be available under law; and
[~~(G)~~] **(H)** eligibility for such other health insurance programs as determined by the commissioner; and

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

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

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

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

§ 9-a. Section 369-ii of the social services law, as added by section 3 of part H of chapter 57 of the laws of 2023, is amended to read as follows:

§ 369-ii. 1332 state innovation program. 1. Authorization. Notwithstanding section three hundred sixty-nine-gg of this title, subject to federal approval, if it is in the financial interest of the state to do so, the commissioner of health is authorized, with the approval of the director of the budget, to establish a 1332 state innovation program pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision twenty-five of section two hundred sixty-eight-c of the public health law. The commissioner of health's authority pursuant to this section is contingent upon obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an application for a waiver for state innovation. The commissioner of health [~~may~~] **shall** take all actions necessary to obtain such approvals**, including seeking any necessary approvals for amendments to the waiver**.

2. Definitions. For the purposes of this section:

(a) "Eligible organization" means an insurer licensed pursuant to article thirty-two or forty-two of the insurance law, a corporation or an organization under article forty-three of the insurance law, or an organization certified under article forty-four of the public health law, including providers certified under section forty-four hundred three-e of the public health law.

(b) "Approved organization" means an eligible organization approved by the commissioner of health to underwrite a 1332 state innovation health insurance plan pursuant to this section.

(c) "Health care services" means:

(i) the services and supplies as defined by the commissioner of health in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner of health for the purposes of defining such benefits, and shall include coverage of and access to the services of any national cancer institute-designated cancer center licensed by the department of health within the service area of the approved organization that is willing to agree to provide cancer-related inpatient, outpatient and medical services to all enrollees in approved organizations' plans in such cancer center's service area under the prevailing terms and conditions that the approved organization requires of other similar providers to be included in the approved organization's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services;

(ii) dental and vision services as defined by the commissioner of health, and

(iii) as defined by the commissioner of health and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting.

(d) "Qualified health plan" means a health plan that meets the criteria for certification described in § 1311(c) of the patient protection

and affordable care act (P.L. 111-148), and is offered to individuals through the NY State of Health, the official health Marketplace, or Marketplace, as defined in subdivision two of section two hundred sixty-eight-a of the public health law.

(e) "Basic health insurance plan" means a health plan providing health care services, separate and apart from qualified health plans, that is issued by an approved organization and certified in accordance with section three hundred sixty-nine-gg of this title.

(f) "1332 state innovation plan" means a standard health plan providing health care services, separate and apart from a qualified health plan and a basic health insurance plan, that is issued by an approved organization and certified in accordance with this section.

3. State innovation plan eligible individual. (a) A person is eligible to receive coverage for health care under this section if they:

(i) reside in New York state and are under sixty-five years of age**, including individuals that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status provided they are determined eligible pursuant to subdivision nine of this section and are determined eligible through the waiver process to receive coverage under this section regardless of direct federal financial support for such individuals**;

(ii) are not eligible for medical assistance under title eleven of this article**, excluding eligibility for limited medical assistance for the treatment of an emergency medical condition authorized pursuant to 42 U.S.C. 1396,** or for the child health insurance plan described in title one-A of article twenty-five of the public health law;

(iii) are not eligible for minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Service Code of 1986, or is eligible for an employer-sponsored plan that is not affordable, in accordance with section 5000A(f) of such code; and

(iv) have household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; **provided,** however, **that** MAGI eligible noncitizens lawfully present in the United States**, and individuals that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status** with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this section [~~**if such noncitizen would be ineligible for medical assistance under title eleven of this article due to their immigration status**~~].

(b) Subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this section who but for their eligibility under this section would be eligible for coverage pursuant to subparagraphs two or four of paragraph (b) of subdivision one of section three hundred sixty-six of this article, shall be administratively enrolled, as defined by the commissioner of health, in medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

(c) Subject to federal approval, an individual who is eligible for and receiving coverage for health care services pursuant to this section is

eligible to continue to receive health care services pursuant to this section during the individual's pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this section.

(d) For the purposes of this section, 1332 state innovation program eligible individuals are prohibited from being treated as qualified individuals under section 1312 of the Affordable Care Act and as eligible individuals under section 1331 of the ACA and enrolling in qualified health plan through the Marketplace or standard health plan through the Basic Health Program.

4. Enrollment. (a) Subject to federal approval, the commissioner of health is authorized to establish an application and enrollment procedure for prospective enrollees. Such procedure will include a verification system for applicants, which must be consistent with 42 USC § 1320b-7.

(b) Such procedure shall allow for continuous enrollment for enrollees to the 1332 state innovation program where an individual may apply and enroll for coverage at any point.

(c) Upon an applicant's enrollment in a 1332 state innovation plan, coverage for health care services pursuant to the provisions of this section shall be retroactive to the first day of the month in which the individual was determined eligible, except in the case of program transitions within the Marketplace.

(d) A person who has enrolled for coverage pursuant to this section, and who loses eligibility to enroll in the 1332 state innovation program for a reason other than [~~citizenship status,~~] lack of state residence, [~~failure to provide a valid social security number,~~] providing inaccurate information that would affect eligibility when requesting or renewing health coverage pursuant to this section, or failure to make an applicable premium payment, before the end of a twelve month period beginning on the effective date of the person's initial eligibility for coverage, or before the end of a twelve month period beginning on the date of any subsequent determination of eligibility, shall have their eligibility for coverage continued until the end of such twelve month period, provided that the state receives federal approval for using funds under an approved 1332 waiver.

5. Premiums. Subject to federal approval, the commissioner of health shall establish premium payments enrollees in a 1332 state innovation plan shall pay to approved organizations for coverage of health care services pursuant to this section. Such premium payments shall be established in the following manner:

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

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

6. Cost-sharing. The commissioner of health shall establish cost-sharing obligations for enrollees, subject to federal approval, including childbirth and newborn care consistent with the medical assistance

program under title eleven of this article. There shall be no cost-sharing obligations for enrollees for:

(a) dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision two of this section; and

(b) services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision two of this section.

7. Rates of payment. (a) The commissioner of health shall select the contract with an independent actuary to study and recommend appropriate reimbursement methodologies for the cost of health care service coverage pursuant to this section. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of reimbursement methodologies, including but not limited to; the adequacy of rates of payment in relation to the population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards.

(b) Upon consultation with the independent actuary and entities representing approved organizations, the commissioner of health shall develop reimbursement methodologies and fee schedules for determining rates of payment, which rates shall be approved by the director of the division of the budget, to be made by the department to approved organizations for the cost of health care services coverage pursuant to this section. Such reimbursement methodologies and fee schedules may include provisions for capitation arrangements.

(c) The commissioner of health shall have the authority to promulgate regulations, including emergency regulations, necessary to effectuate the provisions of this subdivision.

(d) The department of health shall require the independent actuary selected pursuant to paragraph (a) of this subdivision to provide a complete actuarial report, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates for the 1332 state innovation plan authorized under this section. Such report shall be provided annually to the temporary president of the senate and the speaker of the assembly.

8. An individual who is lawfully admitted for permanent residence, permanently residing in the United States under color of law, or who is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15), and who would be ineligible for medical assistance under title eleven of this article due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall be considered to be ineligible for medical assistance for purposes of paragraphs (b) and (c) of subdivision three of this section.

9. **(a) In determining eligibility for residents of the state that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status, the commissioner of health may place limitations on enrollment to ensure that the costs associated with rendering services to this population do not exceed the revenues anticipated to be transferred to the 1332 state innovation program fund, pursuant to section ninety-eight-d of the state finance law. In establishing any limitations pursuant to this subdivision the commissioner of health shall enroll as many individuals as reasonably practicable while ensuring continual coverage for such additional individuals based on current and anticipated 1332 state innovation program fund reserves.**

**(b) In determining any limitations on enrollment, the commissioner of health shall determine income bands for such individuals from zero to two hundred fifty percent of the federal poverty line defined and annu-**

ally revised by the United States department of health and human services for a household of the same size. The commissioner of health shall prioritize the enrollment of individuals from the lowest income band first and then the remaining income bands in ascending order.

(c) Notwithstanding the provisions of paragraph (b) of this subdivision, the commissioner of health may also include subsets of the population whose continued health and well-being would be significantly at risk without routine access to health care. Population subsets to be prioritized for enrollment shall be determined by the commissioner of health and shall include but not be limited to: (i) individuals with life threatening conditions, (ii) individuals in need of an organ transplant; and (iii) individuals with significant behavioral health issues including but not limited to serious mental illness or substance use disorder.

10. The commissioner is authorized to seek a waiver or other applicable federal approval for any additional monies to support the 1332 state innovation program that may be associated with a reduction in the utilization of treatment for an emergency medical condition authorized pursuant to 42 U.S.C. 1396. Any additional monies shall be transferred to the 1332 state innovation program fund established pursuant to section ninety-eight-d of the state finance law and used for such purposes.

11. Reporting. The commissioner of health shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall include, at a minimum, an analysis of the 1332 state innovation program and its impact on the financial interest of the state; its impact on the Marketplace including enrollment and premiums; its impact on the number of uninsured individuals in the state; its impact on the Medicaid global cap; any enrollment limitations established pursuant to subdivision nine of this section including the rationale and supporting fiscal calculations used to justify such limitation, including any historical data, if available, for the previous three years related to any previous limitations of enrollment, funds transferred to the 1332 state innovation program fund pursuant to section ninety-eight-d of the state finance law, and totals on any savings to the state due to coverage of residents of the state that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status; and the demographics of the 1332 state innovation program enrollees including age and immigration status.

[~~10.~~] 12. Severability. If the secretary of health and human services or the secretary of the treasury do not approve any provision of the application for a state innovation waiver, such decision shall in no way affect or impair any other provisions that the secretaries may approve under this section.

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024; provided, however, that section six of this act shall only take effect upon the commissioner of health obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an amended application for a waiver for state innovation pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision 25 of section 268-c of the public health law; provided, further, that section nine-a of this act shall take effect on the same date and in the same manner as section 3 of part H of chapter 57 of the laws of 2023, takes effect; and provided, further, that the commissioner of health shall notify the legislative

bill drafting commission upon the occurrence of the enactment of the legislation provided for in section six of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART K

Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part F of chapter 57 of the laws of 2023, is amended to read as follows:

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

and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, between July 1, 2018 and June 30, 2019, between July 1, 2019 and June 30, 2020, between July 1, 2020 and June 30, 2021, between July 1, 2021 and June 30, 2022, between July 1, 2022 and June 30, 2023, [~~and~~] between July 1, 2023 and June 30, 2024**, and between July 1, 2024 and June 30, 2025** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three

million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part F of chapter 57 of the laws of 2023, is amended to read as follows:

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

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

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

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part F of chapter 57 of the laws of 2023, are amended to read as follows:

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

excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, during the period July 1, 2018 to June 30, 2019, during the period July 1, 2019 to June 30, 2020, during the period July 1, 2020 to June 30, 2021, during the period July 1, 2021 to June 30, 2022, during the period July 1, 2022 to June 30, 2023, [~~and~~] during the period July 1, 2023 to June 30, 2024**, and during the period July 1, 2024 to June 30, 2025** allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

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

covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024**, or covering the period July 1, 2024 to June 30, 2025** shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

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

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

1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020, or covering the period July 1, 2020 to June 30, 2021, or covering the period July 1, 2021 to June 30, 2022, or covering the period July 1, 2022 to June 30, 2023, or covering the period July 1, 2023 to June 30, 2024**, or covering the period July 1, 2024 to June 30, 2025** that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

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

1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018, and covering the period July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to June 30, 2020, and covering the period July 1, 2020 to June 30, 2021, and covering the period July 1, 2021 to June 30, 2022, and covering the period July 1, 2022 to June 30, 2023 for, and covering the period July 1, 2023 to June 30, 2024**, and covering the period July 1, 2024 to June 30, 2025** a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 4 of part F of chapter 57 of the laws of 2023, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [~~2024~~] **2025**; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [~~2024~~] **2025**, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [~~2024~~] **2025** policy periods; in the event and to the extent physicians and

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

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

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

30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020, or July 1, 2020 to June 30, 2021, or July 1, 2021 to June 30, 2022, or July 1, 2022 to June 30, 2023, or July 1, 2023 to June 30, 2024**, or July 1, 2024 to June 30, 2025** as applicable.

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

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

§ 6. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part F of chapter 57 of the laws of 2023, is amended to read as follows:

§ 20. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent

excess coverage for the coverage period ending the thirtieth of June, two thousand [~~twenty-three~~] twenty-four, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [~~twenty-three~~] twenty-four; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand [~~twenty-three~~] twenty-four exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [~~twenty-three~~] twenty-four, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand [~~twenty-three~~] twenty-four, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [~~twenty-three~~] twenty-four and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [~~twenty-three~~] twenty-four.

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

## PART L

Intentionally Omitted

## PART M

Section 1. Subparagraph 3 of paragraph (b) of subdivision 4 of section 366 of the social services law, as added by section 2 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

PART N

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

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

(e) notwithstanding section sixty-five hundred thirty of the education law, issue a non-patient specific statewide standing order for the provision of doula services for pregnant, birthing, and postpartum individuals through twelve months postpartum.

§ 2. Subdivision 3 of section 2504 of the public health law, as added by chapter 976 of the laws of 1984, is amended and a new subdivision 3-a is added to read as follows:

3. Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to [~~prenatal care~~] the pregnancy.

3-a. Any person may give effective consent for reproductive health care, including, but not limited to, a contraceptive device or medication or abortion, and without needing to provide a reason.

§ 3. Intentionally omitted.

§ 4. The public health law is amended by adding a new section 2599-bb-1 to read as follows:

§ 2599-bb-1. Contraception. 1. A health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice, may prescribe or distribute a contraceptive device or medication when, according to the practitioner's reasonable and good faith professional judgment based on the facts of the patient's case, they determine the patient is able to medically tolerate such treatment.

2. This article shall be construed and applied consistent with and subject to applicable laws and applicable and authorized regulations governing health care procedures.

§ 5. Intentionally omitted.

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

PART O

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

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

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

9-a. (a) **(i)** [~~**As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for**~~] **For** periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand [~~**seven, establish**~~] **twenty-five, adopt and implement the uniform** financial [~~**aid policies and procedures, in accordance with the provisions of this subdivision,**~~] **assistance form and policy, to be developed and issued by the commissioner. This section shall apply to any general hospital including any affiliated providers or entity acting on the general hospital's or affiliated provider's behalf. As used in this section, "affiliated provider" means a provider that is billing for medical goods or services that were delivered at a general hospital that is: (A) employed by the hospital; (B) under a professional services agreement with the hospital; or (C) a clinical faculty member of a medical school or other school that trains individuals to be providers and that is affiliated with the hospital or health system. General hospitals, shall implement the uniform policy and form** for reducing **general hospital** charges otherwise applicable to low-income individuals [~~**without health insurance, or who have exhausted their health insurance benefits, and**~~] who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts. **Immigration status shall not be an eligibility criterion for the purpose of determining financial assistance under this section.**

**(ii) A general hospital may use the New York state of health marketplace eligibility determination page to establish the patient's household income and residency in lieu of the financial application form, provided it has secured the consent of the patient. A general hospital shall not require a patient to apply for coverage through the New York state of health marketplace in order to receive care or financial assistance.**

**(iii) Upon submission of a completed application form, the patient is not liable for any bills and no interest may accrue until the general hospital has rendered a decision on the application in accordance with this subdivision.**

(b) Such reductions from charges for [~~**uninsured**~~] patients with incomes below at least [~~**three**~~] **six** hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed [~~**the**~~

~~greater of~~] the amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services~~] provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

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

(ii) For patients with incomes between at least [~~one~~] two hundred [~~one~~] percent and [~~one~~] up to four hundred [~~fifty~~] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases from the nominal amount described in subparagraph (i) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the [~~greater of the~~] amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services~~] provided pursuant to title XIX of the federal social security act (medicaid). After receipt of thirty-six payments at the agreed upon monthly amount, the patient's bill shall be considered paid in full and any and all collection activities on any balance that remains unpaid shall be prohibited;

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

~~(iv)~~] For patients with incomes between at least [~~two~~] four hundred [~~fifty-one~~] percent and [~~three~~] six hundred percent of the federal poverty level, the hospital shall collect no more than the [~~greater of the~~] amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services~~] provided pursuant to title XIX of the federal social security act (medicaid). After receipt of sixty payments at the agreed upon monthly amount, the patient's bill shall be considered paid in full and any and all collection activities on any balance that remains unpaid shall be prohibited; and

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

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

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

(c) [~~Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each~~] Each general hospital [~~participating in the pool~~] shall ensure that every patient is made aware of the existence of [~~such policies and procedures~~] the uniform financial assistance form and policy and is provided, in a timely manner, with a [~~summary~~] copy of [~~such policies and procedures upon request~~] the policy and form at intake and discharge. [~~Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures~~] A plain language summary of the collections process must also be made available. A general hospital shall require the written notification of patients or their authorized representatives during the intake and registration process, during discharge of the patient, through the conspicuous posting of language-appropriate information in the general hospital, including emergency departments, waiting areas and other places patients congregate, and through information on bills and statements sent to patients, that financial [~~aid~~] assistance may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take

place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, during discharge of the patient, and through information on bills and statements sent to patients, that financial [~~aid~~] assistance may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph. General hospitals shall post the uniform financial assistance application policy and form, and the summary of the collection process, in a conspicuous location and downloadable form on the general hospital's website. The commissioner shall post the uniform financial assistance form and policy in downloadable form on the department's hospital profile page or any successor website.

(d) [~~Such policies and procedures~~] The commissioner shall provide application materials to general hospitals, including the uniform financial assistance application form and policy. These application materials shall include a notice to patients that upon submission of a completed application form, the patient shall not be liable for any bills until the general hospital has rendered a decision on the application in accordance with this subdivision. The application materials shall include specific information as the income levels used to determine eligibility for financial assistance and the means to apply for assistance. Nothing in this subdivision shall be construed as precluding the use of presumptive eligibility determinations by hospitals on behalf of patients. The uniform application form and policy shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, [~~such policies and procedures~~] the uniform policy shall also provide for the use of installment plans for the payment of outstanding balances by patients [~~pursuant to the provisions of the hospital's financial assistance policy~~]. The monthly payment under such a plan shall not exceed [~~ten~~] five percent of the gross monthly income of the patient[~~, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments~~]. Installment plan payments shall not be required to begin before one hundred eighty days after the date of the service or discharge, whichever is later. The policy shall allow the patient and the hospital to mutually agree to modify the terms of an installment plan. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed [~~the rate for a ninety-day security issued by the United States Department of Treasury, plus .5~~] two percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. [~~If such policies and procedures~~] The uniform policy shall not include a requirement of a deposit prior to [~~non-emergent,~~] medically-necessary care[~~, such deposit must be included as part of any financial aid consideration~~]. [~~Such policies and procedures~~] The hospital shall refund any payments made by the patient before the determination of eligibility for financial assistance that exceeds the patient's liability after discounts are

applied. The uniform policy shall be applied consistently to all eligible patients.

(e) [~~Such policies and procedures~~] The uniform policy shall permit patients to apply for assistance [~~within at least ninety days of the date of discharge or date of service and provide at least twenty days for patients to submit a completed application~~] at any time during the collection process. [~~Such policies and procedures may require that~~] A determination that a patient is eligible for financial assistance shall be valid for a minimum of twelve months and will apply to all outstanding medical bills. A hospital may use credit scoring software for the purposes of establishing income eligibility and approving financial assistance, but only if the hospital makes clear to the patient that providing a social security number is not mandatory and the scoring does not negatively impact the patient's credit score. However, credit scoring software shall not be solely relied upon by the hospital in denying a patient's application for financial assistance. Further, propensity-to-pay scores shall not disqualify patients who otherwise qualify for eligibility from receiving financial assistance. The uniform policy and form shall allow patients seeking [~~payment adjustments~~] financial assistance to provide [~~appropriate~~] the following financial information and documentation in support of their application[~~, provided, however, that such application process shall not be unduly burdensome or complex.~~]: paychecks or paystubs; unemployment documentation; social security income; rent receipts; a letter from the patient's employer attesting to the patient's gross income; documentation of eligibility for other means-tested government benefits; or, if none of the aforementioned information and documentation are available, a written self-attestation of the patient's income may be used. General hospitals shall[~~, upon request,~~] take measurable steps to assist patients in understanding the [~~hospital's policies and procedures~~] uniform policy and form and in applying for [~~payment adjustments~~] financial assistance. [~~Application forms shall be printed~~] The commissioner shall translate the uniform financial assistance application form and policy into the "primary languages" of each general hospital. Each general hospital shall post these materials to its website and make such materials available to patients through printed copies in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency necessary for effective communication with health care providers, or (ii) spoken by [~~non-English~~] limited-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. [~~Such policies and procedures~~] The uniform financial assistance policy shall require that the hospital issue any [~~denial/approval~~] denial or approval of such application in writing, which clearly communicates the amount of assistance granted, any amounts still owed, with information on how to appeal the [~~denial~~] decision and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first

applying for coverage **that will provide reimbursement for the services that were rendered in relation to such financial assistance application** under title XIX of the social security act (medicaid) or another **publicly-subsidized** insurance program if[~~, in the judgment of the hospital,~~] the patient [~~may be~~] **is** eligible for medicaid or another **publicly-subsidized** insurance program, and upon the patient's cooperation in following the [~~hospital's~~] **uniform** financial assistance application [~~requirements~~] **policy and form**, including the provision of information needed to make a determination on the patient's application in accordance with the [~~hospital's financial assistance~~] **uniform** policy**, provided, however, this requirement shall not apply to any patient that would otherwise not qualify for coverage based on their immigration status. Any information gathered for such coverage determination shall be kept confidential and shall not be utilized or disclosed by the general hospital, or any other party, for any purpose except to assist the patient in obtaining coverage. The hospital shall inform patients on how to file a complaint against the hospital or a debt collector that is contracted on behalf of the hospital regarding the patient's bill. General hospitals are required to take reasonable measures to determine if a patient is eligible for financial assistance including prior to making a referral to a third-party debt collector or other extraordinary collections measures**.

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

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

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

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

(g) [~~Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's primary service area.~~] For patients determined to be eligible for financial [~~aid~~] **assistance** under the terms of [~~a hospital's~~] **the uniform** financial [~~aid~~] **assistance** policy, [~~such policies and procedures~~] **the**

uniform financial assistance policy shall prohibit any limitations on financial [~~aid~~] assistance for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

(h) [~~Such policies and procedures shall not permit the forced~~] The uniform policy shall prohibit the denial of admission or denial of treatment for services that are reasonably anticipated to be medically necessary because the patient has an unpaid medical bill. A hospital or its agent shall not commence a legal action or force a sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill, and shall [~~require the hospital to refrain from sending~~] not send an account to collection [~~if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. Such policies and procedures~~] until the hospital has determined that the patient is not eligible for financial assistance. The uniform policy shall prohibit the sale or transfer of medical debt accumulated pursuant to this section to a third party, unless the third party explicitly purchases such medical debt in order to relieve the debt of the patient. The uniform policy shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection agency obtain the hospital's written consent prior to commencing a legal action. [~~Such policies and procedures~~] The uniform policy shall prohibit a hospital from commencing a legal action related to the recovery of medical debt or unpaid bills against patients with incomes at or below six hundred percent of the federal poverty level. In any legal action related to the recovery of medical debt or unpaid bills by or on behalf of a hospital, the complaint shall be accompanied by an affidavit by the hospital's chief financial officer stating that based upon the hospital's reasonable effort to determine the patient's income, the patient whom they are taking legal action against does not have an income at or below six hundred percent of the federal poverty level. The uniform policy shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in [~~such policies and procedures~~] the uniform policy, and require the implementation of a mechanism for the general hospital to measure its compliance with [~~such policies and procedures~~] the uniform policy. [~~Such policies and procedures~~] The uniform policy shall require that any collection agency, or agent of the general hospital under contract with a general hospital for the collection of debts follow the hospital's financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. [~~Such policies and procedures~~] The uniform policy shall prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services medicaid payment is available.

(i) Reports required to be submitted to the department by each general hospital [~~as a condition for participation in the pools, and which contain~~], in accordance with applicable regulations, shall at a minimum contain: (i) a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compli-

ance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

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

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

[~~(iii)~~] (iv) the number of patients, **including their age, race, ethnicity, gender and insurance status,** organized according to United States postal service zip code, who applied for financial assistance pursuant to the hospital's financial assistance policy, and the number, organized according to United States postal service zip code, whose applications were approved and whose applications were denied;

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

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

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

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

[~~(viii)~~] (ix) the number of **referrals to collection agents or contracted external collection vendors, court cases, and** liens placed on [~~the primary~~] **any** residences of patients through the collection process used by a hospital.

(j) [~~Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material which is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility.~~] **The commissioner shall include the data collected under paragraph (i) of this subdivision in regular audits of the annual general hospital institutional cost report.**

(k) [~~In the event it is determined by the commissioner that the state will be unable to secure all necessary federal approvals to include, as part of the state's approved state plan under title nineteen of the federal social security act, a requirement, as set forth in paragraph one of this subdivision, that compliance with this subdivision is a condition of participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article, then such condition of participation shall be deemed null and void and, notwithstanding~~] **Notwithstanding** section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for

a civil penalty not to exceed ten thousand dollars for each such violation. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

(l) A hospital or its collection agent shall not commence a civil action against a patient or delegate a collection activity to a debt collector for nonpayment for at least one hundred eighty days after the first post-service bill is issued and until a hospital has made reasonable efforts to determine whether a patient qualifies for financial assistance. A hospital or its collection agency, lawyer or firm shall not commence a civil action against a patient or delegate a collection activity to a debt collector, if: the hospital was notified that an appeal or a review of a health insurance decision is pending within the immediately preceding sixty days; or the patient has a pending application for or qualifies for financial assistance.

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

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

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

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

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

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

(c) "Provider offices" shall mean either of the following:

(i) An office of a health care provider in solo practice; or

(ii) An office in which services or goods are personally provided by the health care provider or by employees in that office, or personally by independent contractors in that office, in accordance with law. Employees and independent contractors shall be licensed or certified when licensure or certification is required by law.

2. It shall be prohibited for any individual to complete any portion of an application for medical financial products for the patient or otherwise arrange for or establish an application that is not completely filled out by the patient.

§ 519-a. Medical financial products; payment for health care services. 1. For purposes of this section, the following terms shall have the following meanings:

(a) "Credit card" shall have the same meaning as in section five hundred eleven of this article.

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

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

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

§ 5. This act shall take effect January 1, 2025; provided, however, that if section 1 of subpart C of part Y of chapter 57 of the laws of 2023 shall not have taken effect on or before such date then section one of this act shall take effect on the same date and in the same manner as such chapter of the laws of 2023 takes effect.

PART P

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

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

§ 2. Section 5 of chapter 21 of the laws of 2011 amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, as amended by section 5 of part CC of chapter 57 of the laws of 2022, is amended to read as follows:

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

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

PART Q

Intentionally Omitted

PART R

Intentionally Omitted

PART S

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

§ 2825-i. Health care facility transformation program: statewide VI. 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. The program shall also provide funding, subject to lawful appropriation, in support of capital projects, debt retirement, working capital or other non-capital projects that facilitate furthering such transformational goals.

2. The commissioner shall enter into an agreement with the president of the dormitory authority of the state of New York pursuant to section sixteen hundred eighty-r of the public authorities law, which shall apply to this agreement, subject to the approval of the director of the division of the budget, for the purposes of the distribution and administration of available funds pursuant to such agreement, and made available pursuant to this section and appropriation. Such funds may be awarded and distributed by the department for grants to health care providers including but not limited to, hospitals, residential health care facilities, adult care facilities licensed under title two of article seven of the social services law, diagnostic and treatment centers licensed or granted an operating certificate under this chapter, clinics, including but not limited to those licensed or granted an operating certificate under this chapter or the mental hygiene law, children's residential treatment facilities licensed under article thirty-one of the mental hygiene law, assisted living programs approved by the department pursuant to section four hundred sixty-one-l of the social services law, behavioral health facilities licensed or granted an operating certificate pursuant to articles thirty-one and thirty-two of the mental hygiene law, home care providers certified or licensed under article thirty-six of this chapter, primary care providers, hospices licensed or granted an operating certificate pursuant to article forty of this chapter, community-based programs funded under the office of mental health, the office of addiction services and supports, the office for people with developmental disabilities, or through local governmental units as defined under article forty-one of the mental hygiene law, independent practice associations or organizations, residential facilities or day program facilities licensed or granted an operating certificate under article sixteen of the mental hygiene law, family and child service providers licensed under article twenty-nine-I of this chapter, and midwifery birth centers established pursuant to this chapter. A copy of such agreement, and any amendments thereto, shall be provided by the department to the chair of the senate finance committee, the chair of the assembly ways and means committee, and the director of the division of the budget no later than thirty days after such agreement is finalized. Projects awarded, in whole or part, under sections twenty-eight hundred twenty-five-a and twenty-eight hundred twenty-five-b of this article shall not be eligible for grants or awards made available under this section.

3. Notwithstanding section one hundred sixty-three of the state finance law, or any inconsistent provision of law to the contrary, up to one billion five hundred million dollars of the funds appropriated for this program shall be awarded, without a competitive bid or request for proposal process, for grants to health care providers, as defined in subdivision two of this section. Awards made pursuant to this subdivision shall provide funding for capital projects, debt retirement, working capital or other non-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 cyber security and protect patient data, to improve the quality of care and to ensure financial sustainability of health care providers, and develop capacity in underserved areas of the state. For the purposes of this section, the development of capacity in underserved areas shall include new construction and renovation projects in areas determined to be underserved by the department.

4. Selection of awards made by the department pursuant to subdivisions three and four of this section shall be contingent on an evaluation process acceptable to the commissioner and approved by the director of the division of the budget. Disbursement of awards shall be conditioned on the awardee achieving certain process and performance metrics and milestones as determined by the commissioner. Such metrics and milestones shall be structured to ensure that the goals of the project are achieved, and such metrics and milestones shall be included in grant disbursement agreements or other contractual documents as required by the commissioner. In making awards pursuant to this section, the department shall take into account the geographic distribution of funding previously granted through sections twenty-eight hundred twenty-five-d, twenty-eight hundred twenty-five-e, twenty-eight hundred twenty-five-f, twenty-eight hundred twenty-five-g, and twenty-eight hundred twenty-five-h of this article.

5. The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, and senate and assembly health committees, until such time as the department determines that the projects that receive funding pursuant to this section are substantially complete. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include, for each award, the name of the health care provider as defined in subdivision two of this section, a description of the project or purpose, the amount of the award, disbursement date, and status of achievement of process and performance metrics and milestones pursuant to subdivision four 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, 2024.

PART T

Section 1. Subdivision 1 of section 2130 of the public health law, as amended by chapter 308 of the laws of 2010, is amended to read as follows:

1. (a) Every physician or other person authorized by law to order diagnostic tests or make a medical diagnosis, or any laboratory performing such tests shall immediately [~~(a)~~] (i) upon determination that a person is [~~infected~~] positive/reactive with human immunodeficiency virus (HIV), [~~(b)~~] (ii) upon diagnosis [~~that a person is afflicted~~] with [~~the disease known as~~] acquired immune deficiency syndrome (AIDS), [~~(c)~~]

(iii) upon diagnosis [~~that a person is afflicted~~] with HIV related illness, and [~~(d)~~] (iv) upon periodic monitoring of HIV infection by any laboratory tests report such case or data to the commissioner.

(b) Any permitted clinical laboratory, as defined in section five hundred seventy-one of this chapter, performing such diagnostic tests shall also, upon determination that a test result is not positive/reactive for HIV, report such negative HIV test result to the commissioner.

§ 2. Subdivision 1 of section 2102 of the public health law is amended to read as follows:

1. Whenever any laboratory examination discloses evidence of communicable disease, and for hepatitis B virus or syphilis upon determination that a test result is not positive/reactive, the results of such examination together with all required pertinent facts, shall be immediately reported by the person in charge of the laboratory or the person making such examination to the local or state health official to whom the attending physician is required to report such case.

§ 3. The public health law is amended by adding a new section 2172 to read as follows:

§ 2172. HCV infection; duty to report. In addition to reporting that a hepatitis C virus (HCV) clinical laboratory test is reactive/positive as required by section twenty-one hundred two of this article, any permitted clinical laboratory, as defined in section five hundred seventy-one of this chapter, performing such tests shall also, upon determination that a test result is not positive/reactive with HCV, report such negative HCV test result to the commissioner.

§ 4. Section 2781 of the public health law, as amended by chapter 308 of the laws of 2010, subdivisions 1 and 2 as amended by chapter 502 of the laws of 2016 and subdivision 4 as amended by section 2 of part A of chapter 60 of the laws of 2014, is amended to read as follows:

§ 2781. HIV related testing. 1. Except as provided in section three thousand one hundred twenty-one of the civil practice law and rules, or unless otherwise specifically authorized or required by a state or federal law, no person shall order the performance of an HIV related test without first, at a minimum, [~~orally advising~~] providing notice by means readily accessible in multiple languages to the protected individual, or, when the protected individual lacks capacity to consent, a person authorized to consent to health care for such individual, that an HIV-related test is being performed, or over the objection of such individual or authorized persons. Such [~~advisement and objection, when applicable~~] notice may be provided orally, in writing, by prominently displayed signage, or by electronic means or other appropriate form of communication. Such notice shall include information that HIV testing is voluntary. A refusal of an HIV related test shall be noted in the individual's record.

2. A person ordering the performance of an HIV related test shall provide either directly or through a representative to the subject of an HIV related test or, if the subject lacks capacity to consent, to a person authorized pursuant to law to consent to health care for the subject, an explanation that:

(a) HIV causes AIDS and can be transmitted through sexual activities and needle-sharing, by pregnant women to their fetuses, and through breastfeeding infants;

(b) there is treatment for HIV that can help an individual stay healthy;

(c) individuals with HIV or AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or multiply infected with HIV;

(d) testing is voluntary and can be done anonymously at a public testing center;

(e) the law protects the confidentiality of HIV related test results;

(f) the law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences; and

(g) the law requires that an individual be advised before an HIV-related test is performed, and that no test shall be performed over his or her objection.

Protocols shall be in place to ensure compliance with this section.

4. [~~A person authorized pursuant to law to order the performance of an HIV related test shall provide directly or through a representative to the person seeking such test, an opportunity to remain anonymous through use of a coded system with no linking of individual identity to the test request or results.~~] A health care provider who is not authorized by the commissioner to provide HIV related tests on an anonymous basis shall refer a person who requests an anonymous test to a test site which does provide anonymous testing. The provisions of this subdivision shall not apply to a health care provider ordering the performance of an HIV related test on an individual proposed for insurance coverage.

5. At the time of communicating the test result to the subject of the test, a person ordering the performance of an HIV related test shall, directly or through a representative:

(a) in the case of a test indicating evidence of HIV infection, provide the subject of the test or, if the subject lacks capacity to consent, the person authorized pursuant to law to consent to health care for the subject with counseling or referrals for counseling:

(i) for coping with the emotional consequences of learning the result;

(ii) regarding the discrimination problems that disclosure of the result could cause;

(iii) for behavior change to prevent transmission or contraction of HIV infection;

(iv) to inform such person of available medical treatments; [~~and~~]

(v) regarding the need to notify his or her contacts**; and**

**(vi) regarding pre- and post-exposure prophylaxis medications available to sexual partners to prevent HIV infection**; and

(b) in the case of a test not indicating evidence of HIV infection, provide (in a manner which may consist of oral or written reference to information previously provided) the subject of the test, or if the subject lacks capacity to consent, the person authorized pursuant to law to consent to health care for the subject, with information**:**

**(i)** concerning the risks of participating in high risk sexual or needle-sharing behavior**; and**

**(ii) regarding pre- and post-exposure prophylaxis medications available to prevent HIV infection**.

5-a. With the consent of the subject of a test indicating evidence of HIV infection or, if the subject lacks capacity to consent, with the consent of the person authorized pursuant to law to consent to health care for the subject, the person who ordered the performance of the HIV related test, or such person's representative, shall provide or arrange with a health care provider for an appointment for follow-up medical care for HIV for such subject.

6. The provisions of this section shall not apply to the performance of an HIV related test:

(a) by a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals provided, however, that where the test results are communicated to the subject, post-test counseling, as described in subdivision five of this section, shall nonetheless be required; or

(b) for the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher; or

(c) on a deceased person, when such test is conducted to determine the cause of death or for epidemiological purposes; or

(d) conducted pursuant to section twenty-five hundred-f of this chapter; or

(e) in situations involving occupational exposures which create a significant risk of contracting or transmitting HIV infection, as defined in regulations of the department and pursuant to protocols adopted by the department,

(i) provided that:

(A) the person who is the source of the occupational exposure is deceased, comatose or is determined by his or her attending health care professional to lack mental capacity to consent to an HIV related test and is not reasonably expected to recover in time for the exposed person to receive appropriate medical treatment, as determined by the exposed person's attending health care professional who would order or provide such treatment;

(B) there is no person available or reasonably likely to become available who has the legal authority to consent to the HIV related test on behalf of the source person in time for the exposed person to receive appropriate medical treatment; and

(C) the exposed person will benefit medically by knowing the source person's HIV test results, as determined by the exposed person's health care professional and documented in the exposed person's medical record;

(ii) in which case

(A) a provider shall order an anonymous HIV test of the source person; and

(B) the results of such anonymous test, but not the identity of the source person, shall be disclosed only to the attending health care professional of the exposed person solely for the purpose of assisting the exposed person in making appropriate decisions regarding post-exposure medical treatment; and

(C) the results of the test shall not be disclosed to the source person or placed in the source person's medical record.

7. In the event that an HIV related test is ordered by a physician or certified nurse practitioner pursuant to the provisions of the education law providing for non-patient specific regimens, then for the purposes of this section the individual administering the test shall be deemed to be the individual ordering the test.

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

**(m) undertaking the collection of specimens necessary to test to determine the presence of the hepatitis B virus.**

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

(m) undertaking the collection of specimens necessary to test to determine the presence of the hepatitis B virus.

§ 7. Section 6801 of the education law is amended by adding a new subdivision 10 to read as follows:

10. a. A licensed pharmacist may execute a non-patient specific order for the dispensing of HIV Pre-exposure Prophylaxis (PrEP) prescribed or ordered by the commissioner of health, a physician licensed in this state or a nurse practitioner certified in this state pursuant to rules and regulations promulgated by the commissioner.

b. Prior to dispensing HIV PrEP to a patient, and at a minimum of every twelve months for each returning patient, the pharmacist shall:

(i) ensure that the patient is HIV negative, as documented by a negative HIV test result obtained within the previous seven days from an HIV antigen/antibody test or antibody-only test or from a rapid, point-of-care fingerstick blood test approved by the federal food and drug administration. If the patient does not provide evidence of a negative HIV test in accordance with this paragraph, the pharmacist may recommend or prescribe an HIV test. If the patient tests positive for HIV infection, the pharmacist shall direct the patient to a licensed physician and provide the patient with a list of health care service providers and clinics within the county where the pharmacist is located or adjacent counties;

(ii) provide the patient with a self-screening risk assessment questionnaire, developed by the commissioner of health in consultation with the commissioner, to be reviewed by the pharmacist to identify any known risk factors and assist the patient's selection of an appropriate PrEP medication; and

(iii) provide the patient with a fact sheet, developed by the commissioner of health, that includes but is not limited to, the clinical considerations and recommendations for use of PrEP, the appropriate method for using PrEP, information on the importance of follow-up health care, health care referral information, and the ability of the patient to opt out of practitioner reporting requirements.

c. No pharmacist shall dispense PrEP under this subdivision without receiving training in accordance with regulations promulgated by the commissioner of health in consultation with the commissioner.

d. A pharmacist shall notify the patient's primary health care practitioner, unless the patient opts out of such notification, within seventy-two hours of dispensing PrEP, that PrEP has been dispensed. If the patient does not have a primary health care practitioner, or is unable to provide contact information for their primary health care practitioner, the pharmacist shall provide the patient with a written record of the PrEP medications dispensed, and advise the patient to consult an appropriate health care practitioner.

e. Nothing in this subdivision shall prevent a pharmacist from refusing to dispense a non-patient specific order of PrEP pursuant to this subdivision if, in their professional judgment, potential adverse effects, interactions, or other therapeutic complications could endanger the health of the patient.

§ 8. Section 6801 of the education law is amended by adding a new subdivision 11 to read as follows:

11. A licensed pharmacist within their lawful scope of practice may administer to patients eighteen years of age or older, immunizing agents to prevent mpox pursuant to a patient specific order or a non-patient specific order. When a licensed pharmacist administers an mpox immuniz-

ing agent, they shall comply with subdivisions two, three and four of this section.

§ 9. Section 2307 of the public health law is REPEALED.

§ 9-a. Subdivision 7 of section 6801 of the education law, as added by section 2 of part C of chapter 57 of the laws of 2022, is amended to read as follows:

7. A licensed pharmacist is a qualified health care professional under section five hundred seventy-one of the public health law for the purposes of directing a limited service laboratory and ordering and administering COVID-19 [~~and~~], influenza, and human immunodeficiency virus (HIV) tests authorized by the Food and Drug Administration (FDA), subject to certificate of waiver requirements established pursuant to the federal clinical laboratory improvement act of nineteen hundred eighty-eight.

§ 10. This act shall take effect immediately; provided, however, sections one, two, and three of this act shall take effect on the one hundred eightieth day after it shall have become a law; and provided further that the amendments to subdivision 7 of section 6801 of the education law made by section nine-a of this act shall not affect the repeal of such subdivision 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.

PART U

Section 1. Section 3302 of the public health law is amended by adding a new subdivision 42 to read as follows:

42. "Public health surveillance" means the continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Public health surveillance may be used for all of the following purposes:

(a) as an early warning system for impending public health emergencies;

(b) to document the impact of an intervention;

(c) to track progress towards specified goals;

(d) to monitor and clarify the epidemiology of health outcomes;

(e) to establish public health priorities; and

(f) to inform public health policy and strategies.

§ 2. Subparagraphs (ix) and (x) of paragraph (a) of subdivision 2 of section 3343-a of the public health law, as added by section 2 of part A of chapter 447 of the laws of 2012, are amended and a new subparagraph (xi) is added to read as follows:

(ix) a situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation; [~~or~~]

(x) a practitioner who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner, pursuant to a process established in regulation, and in the discretion of the commissioner[~~.~~]; or

(xi) a practitioner prescribing or ordering a controlled substance for use on the premises of a correctional facility, an inpatient mental

health facility licensed under the mental hygiene law, or a nursing home licensed under article twenty-eight of this chapter.

§ 3. Subdivision 4 of section 3370 of the public health law, as added by chapter 965 of the laws of 1974 and as renumbered by chapter 178 of the laws of 2010, is amended to read as follows:

4. The department shall cause to be expunged or otherwise destroyed, within [~~five~~] ten years from the date of receipt thereof, any record of the name of any patient received by it pursuant to the filing requirements of subdivision six of section thirty-three hundred thirty-one, subdivision four of section thirty-three hundred thirty-three, and subdivision four of section thirty-three hundred thirty-four of this article.

§ 4. Subdivision 1 of section 3371 of the public health law, as amended by chapter 178 of the laws of 2010, paragraphs (d) and (e) as amended and paragraphs (f), (g), (h), (i), and (j) as added by section 4 of part A of chapter 447 of the laws of 2012, is amended to read as follows:

1. No person, who has knowledge by virtue of [~~his or her~~] such person's office of the identity of a particular patient or research subject, a manufacturing process, a trade secret or a formula shall disclose such knowledge, or any report or record thereof, except:

(a) to another person employed by the department, for purposes of executing provisions of this article;

(b) pursuant to judicial subpoena or court order in a criminal investigation or proceeding;

(c) to an agency, department of government, or official board authorized to regulate, license or otherwise supervise a person who is authorized by this article to deal in controlled substances, or in the course of any investigation or proceeding by or before such agency, department or board;

(d) to the prescription monitoring program registry and to authorized users of such registry as set forth in subdivision two of this section;

(e) to a vendor or contractor, as authorized by the department as necessary for the operation and maintenance of the prescription monitoring program registry;

(f) to a practitioner to inform [~~him or her~~] such person that a patient may be under treatment with a controlled substance by another practitioner for the purposes of subdivision two of this section, and to facilitate the department's review of individual challenges to the accuracy of controlled substances histories pursuant to subdivision six of section thirty-three hundred forty-three-a of this article;

[~~(f)~~] (g) to a pharmacist to provide information regarding prescriptions for controlled substances presented to the pharmacist for the purposes of subdivision two of this section and to facilitate the department's review of individual challenges to the accuracy of controlled substances histories pursuant to subdivision six of section thirty-three hundred forty-three-a of this article;

[~~(g)~~] (h) to the deputy attorney general for medicaid fraud control, or [~~his or her~~] such deputy attorney general's designee, in furtherance of an investigation of fraud, waste or abuse of the Medicaid program, pursuant to an agreement with the department;

[~~(h)~~] (i) to a program area within the department for the purpose of conducting public health research, public health surveillance, or education with data contained in the prescription monitoring program registry and not for patient-level outreach:

(i) pursuant to an agreement with the commissioner;

(ii) when the release of such information is deemed appropriate by the commissioner;

(iii) for use in accordance with measures required by the commissioner to ensure that the security and confidentiality of the data is protected;

(iv) for use and retention no longer than ten years; and

(v) provided that disclosure is restricted to individuals within the department who are engaged in public health research, public health surveillance, or education;

(j) to a local health department for the purpose of conducting public health research, public health surveillance, or education and not for patient-level outreach:

(i) pursuant to an agreement with the commissioner;

(ii) when the release of such information is deemed appropriate by the commissioner;

(iii) for use in accordance with measures required by the commissioner to ensure that the security and confidentiality of the data is protected;

(iv) for use and retention no longer than ten years; and

[~~(iv)~~] (v) provided that disclosure is restricted to individuals within the local health department who are engaged in the research or education;

[~~(i)~~] (k) to a medical examiner or coroner who is an officer of or employed by a state or local government, pursuant to [~~his or her~~] such medical examiner's or coroner's official duties; and

[~~(j)~~] (l) to an individual for the purpose of providing such individual with [~~his or her~~] such individual's own controlled substance history or, in appropriate circumstances, in the case of a patient who lacks capacity to make health care decisions, a person who has legal authority to make such decisions for the patient and who would have legal access to the patient's health care records, if requested from the department pursuant to subdivision six of section thirty-three hundred forty-three-a of this article or from a treating practitioner pursuant to subparagraph (iv) of paragraph (a) of subdivision two of this section.

§ 5. Intentionally omitted.

§ 6. Intentionally omitted.

§ 7. Intentionally omitted.

§ 8. Intentionally omitted.

§ 9. Intentionally omitted.

§ 10. Intentionally omitted.

§ 11. Intentionally omitted.

§ 12. Intentionally omitted.

§ 13. Intentionally omitted.

§ 14. Intentionally omitted.

§ 15. Intentionally omitted.

§ 16. Intentionally omitted.

§ 17. Intentionally omitted.

§ 18. Intentionally omitted.

§ 19. Intentionally omitted.

§ 20. Intentionally omitted.

§ 21. Intentionally omitted.

§ 22. Subdivision 2 of section 3342 of the public health law, as amended by chapter 692 of the laws of 1976, is amended to read as follows:

2. An institutional dispenser may dispense controlled substances for use off its premises only pursuant to a prescription, prepared and filed in conformity with this title, provided, however, that, in an emergency situation as defined by rule or regulation of the department, a practitioner in a hospital without a full-time pharmacy may dispense controlled substances to a patient in a hospital emergency room for use off the premises of the institutional dispenser for a period not to exceed twenty-four hours**, unless the federal drug enforcement administration has authorized a longer time period for the purpose of initiating maintenance treatment, detoxification treatment, or both**.

§ 23. Subdivision 1 of section 3302 of the public health law, as amended by chapter 92 of the laws of 2021, is amended to read as follows:

1. "[~~Addict~~] **Person with a substance use disorder**" means a person who habitually uses a controlled substance for a non-legitimate or unlawful use, and who by reason of such use is dependent thereon.

§ 24. Subdivision 1 of section 3331 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

1. Except as provided in titles III or V of this article, no substance in schedules II, III, IV, or V may be prescribed for or dispensed or administered to [~~an addict~~] **a person with a substance use disorder** or habitual user.

§ 25. The title heading of title 5 of article 33 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

DISPENSING TO [~~ADDICTS~~] **PERSONS WITH A SUBSTANCE USE DISORDER** AND HABITUAL USERS

§ 26. Section 3350 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

§ 3350. Dispensing prohibition. Controlled substances may not be prescribed for, or administered or dispensed to [~~addicts~~] **persons with a substance use disorder** or habitual users of controlled substances, except as provided by this title or title III.

§ 27. Section 3351 of the public health law, as added by chapter 878 of the laws of 1972, subdivision 5 as amended by chapter 558 of the laws of 1999, is amended to read as follows:

§ 3351. Dispensing for medical use. 1. Controlled substances may be prescribed for, or administered or dispensed to [~~an addict~~] **a person with a substance use disorder** or habitual user:

(a) during emergency medical treatment unrelated to [~~abuse~~] **such substance use disorder or habitual use** of controlled substances;

(b) who is a bona fide patient suffering from an incurable and fatal disease such as cancer or advanced tuberculosis;

(c) who is aged, infirm, or suffering from serious injury or illness and the withdrawal from controlled substances would endanger the life or impede or inhibit the recovery of such person.

**1-a. A practitioner may prescribe, order and dispense any schedule III, IV, or V narcotic drug approved by the federal food and drug administration specifically for use in maintenance or detoxification treatment to a person with a substance use disorder or habitual user.**

2. Controlled substances may be ordered for use by [~~an addict~~] **a person with a substance use disorder** or habitual user by a practitioner

and administered by a practitioner [~~or~~], registered nurse, or paramedic to relieve acute withdrawal symptoms.

3. Methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be ordered for use of [~~an addict~~] a person with a substance use disorder by a practitioner and dispensed or administered by a practitioner or [~~his~~] such person's designated agent as interim treatment for [~~an addict on a waiting list for admission to an authorized maintenance program~~] a person with a substance use disorder while arrangements are being made for referral to treatment for such addiction to controlled substances.

4. Methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be administered to [~~an addict~~] a person with a substance use disorder by a practitioner or by [~~his~~] such person's designated agent acting under the direction and supervision of a practitioner, as part of a [~~regime~~] regimen designed and intended as maintenance or detoxification treatment or to withdraw a patient from addiction to controlled substances.

5. [~~Methadone~~] Notwithstanding any other law and consistent with federal requirements, methadone, or such other controlled substance designated by the commissioner as appropriate for such use, may be administered or dispensed directly to [~~an addict~~] a person with a substance use disorder by a practitioner or by [~~his~~] such person's designated agent acting under the direction and supervision of a practitioner, as part of a substance [~~abuse or chemical dependence~~] use disorder program approved pursuant to article [~~twenty-three or~~] thirty-two of the mental hygiene law.

§ 28. Section 3372 of the public health law is REPEALED.

§ 29. This act shall take effect immediately.

PART V

Section 1. The opening paragraph of subdivision 1 of section 122-b of the general municipal law, as amended by chapter 471 of the laws of 2011, is amended and a new paragraph (g) is added to read as follows:

[~~Any~~] General ambulance services are an essential service. Every county, city, town [~~or~~] and village, acting individually or jointly or in conjunction with a special district, [~~may provide~~] shall ensure that an emergency medical service, a general ambulance service or a combination of such services are provided for the purpose of providing prehospital emergency medical treatment or transporting sick or injured persons found within the boundaries of the municipality or the municipalities acting jointly to a hospital, clinic, sanatorium or other place for treatment of such illness or injury, [~~and for~~] provided, however, that the provisions of this subdivision shall not apply to a city with a population of one million or more. In furtherance of that purpose, a county, city, town or village may:

(g) Establish a special district for the financing and operation of general ambulance services, including support for agencies currently providing EMS services, as set forth by this section, whereby any county, city, town or village, acting individually, or jointly with any other county, city, town and/or village, through its governing body or bodies, following applicable procedures as are required for the establishment of fire districts in article eleven of the town law or following applicable procedures as are required for the establishment of joint fire districts in article eleven-A of the town law, with such special district being authorized by this section to be established in all or

any part of any such participating county or counties, town or towns, city or cities and/or village or villages. Notwithstanding any provision of this article, rule or regulation to the contrary, any special district created under this section shall not overlap with a pre-existing city, town or village ambulance district unless such existing district is merged into the newly created district. No city, town or village shall eliminate or dissolve a pre-existing ambulance district without express approval and consent by the county to assume responsibility for the emergency medical services previously provided by such district. When a special district is established pursuant to this article, the cities, towns, or villages contained within the county shall not reduce current ambulance funding without such changes being incorporated into the comprehensive county emergency medical system plan.

§ 2. Section 3000 of the public health law, as amended by chapter 804 of the laws of 1992, is amended to read as follows:

§ 3000. Declaration of policy and statement of purpose. The furnishing of medical assistance in an emergency is a matter of vital concern affecting the public health, safety and welfare. Emergency medical services and ambulance services are essential services and shall be available to every person in the state of New York in a reliable manner. Prehospital emergency medical care, other emergency medical services, the provision of prompt and effective communication among ambulances and hospitals and safe and effective care and transportation of the sick and injured are essential public health services and shall be available to every person in the state of New York in a reliable manner.

It is the purpose of this article to promote the public health, safety and welfare by providing for certification of all advanced life support first response services and ambulance services; the creation of regional emergency medical services councils; and a New York state emergency medical services council to develop minimum training standards for certified first responders, emergency medical technicians and advanced emergency medical technicians and minimum equipment and communication standards for advanced life support first response services and ambulance services.

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

1. "Emergency medical service" means [~~initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies~~] a coordinated system of healthcare delivery that responds to the needs of sick and injured adults and children, by providing: essential care at the scene of an emergency, non-emergency, specialty need or public event; community education and prevention programs; ground and air ambulance services; centralized access and emergency medical dispatch; training for emergency medical services practitioners; medical first response; mobile trauma care systems; mass casualty management; medical direction; or quality control and system evaluation procedures.

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

§ 3019. Statewide comprehensive emergency medical system plan. 1. The state emergency medical services council, in collaboration and with final approval of the department, shall develop and maintain a statewide comprehensive emergency medical system plan that shall provide for a coordinated emergency medical system within the state, which shall include but not be limited to:

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

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

(c) coordinating professional medical organizations, hospitals, and other public and private agencies in developing alternative delivery models for persons who are presently using emergency departments for routine, nonurgent and primary medical care to be served appropriately and economically, provided, however, that the provisions of this subdivision shall not apply to a city with a population of one million or more; and

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

2. The statewide comprehensive emergency medical system plan shall be reviewed, updated if necessary, and published every five years on the department's website, or at such earlier 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 adopt the statewide comprehensive emergency medical service system plan, to provide for a coordinated emergency medical system within the region. Such plans shall incorporate all ambulance services with a current EMS operating certificate for response to calls in their designated operating territory and shall be subject to review by the state emergency medical services council and final approval by the department. Any proposed permanent changes to the regional emergency medical system plan, including the dissolution of an ambulance services district or other significant modification of existing coverage shall be submitted in writing to the department no later than one hundred eighty days before the change shall take effect. Such changes shall not be made until receipt of the appropriate departmental approvals.

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, to provide essential emergency medical services for all residents within the county. The county office of emergency medical services shall be responsible for the development, implementation, and maintenance of the comprehensive county emergency medical system plan. Such plans may require review and approval, as determined by the state emergency medical services council, by such council, the regional emergency medical services council and approval by the department. Such plan shall incorporate all ambulance services with a current EMS operating certificate for response to calls in their designated operating territory and shall outline the primary responding agency for requests for service for each part of the county. Any proposed permanent changes to the county emergency medical system plan, including the dissolution of an ambulance services district or other significant modification of existing coverage shall be submitted in writing to the department no later than one hundred eighty days before the change shall take effect. Such changes shall not be made until receipt of the appro-

priate approvals. No county shall remove or reassign an area served by an existing medical emergency response agency where such agency is compliant with all statutory and regulatory requirements, and has agreed to the provision of the approved plan.

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

§ 3019-a. Emergency medical systems training program. 1. The state emergency medical services council shall make recommendations to the department for the department to implement standards related to the establishment of training programs for emergency medical systems that include but are not limited to students, emergency medical service practitioners, emergency medical services agencies, approved educational institutions, geographic areas, facilities, and personnel, and the commissioner shall fund such training programs in full or in part based on state appropriations. Until such time as the department announces the training program established pursuant to this section is in effect, all current standards, curricula, and requirements for students, emergency medical service practitioners, agencies, facilities, and personnel shall remain in effect.

2. The state emergency medical services council, with final approval of the department, shall establish minimum education standards, curricula, and requirements for all emergency medical system educational institutions. No person or educational institution shall profess to provide emergency medical system training without meeting the requirements set forth in regulation and only after approval of the department.

3. The department is authorized to provide, either directly or through contract, for local or statewide initiatives, emergency medical system training for emergency medical service practitioners and emergency medical system agency personnel, using funding including but not limited to allocations to aid to localities for emergency medical services training.

4. Notwithstanding any other provisions of this section, the regional emergency medical services council with jurisdiction over the city of New York shall have authority to establish, subject to the approval of the commissioner, training and educational requirements which shall apply to all emergency medical practitioners working in the 911 system of the city of New York and to determine protocols for the delivery of emergency medical care, including those related to staffing, in the 911 system of the city of New York. Such training and educational requirements and protocols for the delivery of care shall be at least equal or comparable to those applicable to emergency medical service practitioners in other areas of the state.

5. The department may visit and inspect any emergency medical system training program or training center operating under this article to ensure compliance. The department may request the state or regional emergency medical services council's assistance to ensure the compliance, maintenance, and coordination of training programs. Emergency medical services institutions that fail to meet applicable standards and regulations may be subject to enforcement action, including but not limited to revocation, suspension, performance improvement plans, or restriction from specific types of education.

§ 6. Section 3020 of the public health law is amended by adding three new subdivisions 3, 4 and 5 to read as follows:

3. The department, with the approval of the state emergency medical services council, may create or adopt additional standards, training and criteria to become an emergency medical service practitioner credent-

ialled to provide specialized, advanced, or other services that further support or advance the emergency medical system. The department, with approval of the state emergency medical services council may also set standards and requirements to require specialized credentials to perform certain functions in the emergency medical services system.

4. The department, with approval of the state emergency medical services council may also set standards for emergency medical system agencies to become accredited in a specific area to increase system performance and agency recognition.

5. Notwithstanding any other provisions of this section, the regional emergency medical services council with jurisdiction over the city of New York shall have authority to establish, subject to the approval of the commissioner, training and educational requirements which shall apply to all emergency medical practitioners working in the 911 system of the city of New York and to determine protocols for the delivery of emergency medical care, including those related to staffing, in the 911 system of the city of New York. Such training and educational requirements and protocols for the delivery of care shall be at least equal or comparable to those applicable to emergency medical service practitioners in other areas of the state.

§ 7. This act shall take effect six months after it shall have become a law.

PART W

Section 1. The elder law is amended by adding a new section 226 to read as follows:

§ 226. Interagency elder justice task force. 1. There is hereby created within the office an interagency elder justice task force consisting of representatives of state agencies whose work involves elder justice to create greater collaboration and develop overarching strategies, systems, and programs, with the goal of protecting older adults from abuse and mistreatment. The task force shall collaborate to identify consistent policies and programs in elder justice; and facilitate communication and foster collaborative relationships among state agencies.

2. The task force shall consist of the following members or their designees: (a) the director of the office for the aging, who shall serve as chair; (b) the director of the office of victims services; (c) the commissioner of the office of children and family services; (d) the superintendent of financial services; (e) the commissioner of the division of criminal justice services; (f) the commissioner of the office of mental health; (g) the director of the office for the prevention of domestic violence; (h) the commissioner of the department of health; (i) the commissioner of the office for people with developmental disabilities; (j) the superintendent of the New York state police; (k) the executive director of the justice center for the protection of people with special needs; (l) the secretary of state for the department of state's division of consumer protection; (m) two members appointed by the governor; (n) one member appointed by the speaker of the assembly; and (o) one member appointed by the temporary president of the senate.

3. The task force shall request input from stakeholders, advocates, experts, and coalitions.

4. Members appointed to the task force shall have relevant experience and expertise concerning elder justice by virtue of their education, training or lived experience.

5. The task force shall:

(a) develop a cohesive, comprehensive state plan on elder justice that aligns with New York state's elder justice policy and programs across state agency responsibilities;

(b) develop plans for a coordinated and comprehensive response from state and local government and other entities when elder abuse is reported;

(c) facilitate interagency planning and policy development on elder justice;

(d) review and propose specific agency initiatives for their impact on systems and services related to elder justice;

(e) coordinate activities for world elder abuse awareness day and other events;

(f) inform local and state agencies on national developments in elder justice; and

(g) make recommendations to the governor that will improve New York's elder abuse prevention and intervention efforts.

6. The task force shall serve to focus attention on elder justice comprehensively and create a multidisciplinary mechanism to work toward alignment across agencies to help achieve the governor's elder justice priorities.

7. The task force shall meet regularly, but no less than once per month and where otherwise appropriate to fulfill its duties under this chapter. The members of this task force shall serve without compensation, but shall be entitled to reimbursement for all necessary expenses incurred in the performance of their duties.

8. Any vacancies in the membership of the task force shall be filled in the same manner provided for in the initial appointment.

9. The members of the task force shall be appointed no later than one hundred twenty days after the effective date of this act.

§ 2. Within one year of the effective date of this act, in carrying out its functions, the interagency elder justice task force shall hold five public hearings around the state to foster discussions and conduct formal public hearings with requisite public notice to solicit input and recommendations from statewide and regional stakeholder interests. Such task force shall also accept public input in writing. Such task force may utilize remote access such as web conferencing to comply with the provisions of this section.

§ 3. Within two years of the effective date of this act, the interagency elder justice task force shall report its findings and recommendations to the governor, the temporary president of the senate and the speaker of the assembly and shall publicize its findings on the office's website.

§ 4. This act shall take effect immediately and shall expire and be deemed repealed 3 years after such effective date.

## PART X

Intentionally Omitted

## PART Y

Section 1. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program,

the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section 1 of part W of chapter 57 of the laws of 2021, is amended to read as follows:

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

§ 1-a. Section 41.55 of the mental hygiene law is amended by adding a new subdivision (l) to read as follows:

(l) The commissioner shall prepare a written report to be submitted to the governor, the temporary president of the senate, and the speaker of the assembly no later than December thirty-first, two thousand twenty-four and annually thereafter. Such report shall include (1) the total number of local government units or providers who currently utilize this funding pursuant to this section; (2) the purposes for which local government units are utilizing such funding for pursuant to this section; (3) the service categories for which such funding is being used pursuant to this section; (4) a regional breakdown of key metrics related to program operations including, but not limited to, inpatient bed capacity, admissions, discharges, average length of stay, and new individuals served within the community; (5) the amount of funding real-located to community based programs; and (6) any other information determined to be of significance by the commissioner.

§ 2. This act shall take effect immediately; provided, however, that the amendments to section 41.55 of the mental hygiene law made by section one-a of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART Z

Section 1. Section 2 of part NN of chapter 58 of the laws of 2015, amending the mental hygiene law relating to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs, as amended by section 1 of part V of chapter 57 of the laws of 2021, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [~~2024~~] 2027.

§ 1-a. Section 41.35 of the mental hygiene law is amended by adding a new paragraph (f) to read as follows:

(f) The commissioners shall prepare a written report to be submitted to the governor, the temporary president of the senate, and the speaker of the assembly no later than December thirty-first, two thousand twen-ty-four and annually thereafter. Such report shall include: (1) the number of demonstration programs currently operating, their purpose and duration; (2) the number of individuals served by each demonstration program annually; (3) demographic information of those admitted to comprehensive psychiatric emergency programs inclusive of age, race, gender and county of residence; and (4) the number of demonstration programs currently being considered for implementation by the commis-sioners, their purpose and planned implementation date. In the event where no demonstration programs are operating or being considered, the commissioners shall issue a statement to that effect in lieu of a full report.

§ 2. This act shall take effect immediately.

PART AA

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

**(J) This subparagraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at a rate that is not less than the rate that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law.**

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

**(K) This subparagraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such a facility shall be at a rate that is not less than the rate that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law.**

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

**(K) This subparagraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such a facility shall be at a rate that is not less than the rate that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law.**

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

**(J) This subparagraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at a rate that is not less than the rate that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law.**

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

**(12) This paragraph shall apply to outpatient treatment provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental**

hygiene law, or in a facility operated by the office of mental health, or in a crisis stabilization center licensed pursuant to section 36.01 of the mental hygiene law, that is participating in the corporation's provider network. Reimbursement for covered outpatient treatment provided by such facility shall be at a rate that is not less than the rate that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law.

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

(10) This paragraph shall apply to facilities in this state that are licensed, certified, or otherwise authorized by the office of addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Reimbursement for covered outpatient treatment provided by such facilities shall be at a rate that is not less than the rate that would be paid for such treatment pursuant to the medical assistance program under title eleven of article five of the social services law.

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

PART BB

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

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

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

§ 1-a. Section 31.27 of the mental hygiene law is amended by adding a new subdivision (i) to read as follows:

(i) The commissioner shall prepare a written report to be submitted to the governor, the temporary president of the senate, and the speaker of the assembly no later than December thirty-first, two thousand twenty-four and annually thereafter. Such report shall include: (1) the number of comprehensive psychiatric emergency programs currently operating; (2) the number of individuals admitted to a comprehensive psychiatric emergency program annually; (3) the number of individuals seeking care from a comprehensive psychiatric emergency program that does not require the level of care provided; (4) the average wait time for admission to a comprehensive psychiatric emergency program; (5) the number of individuals successfully admitted to alternative care after discharge; and (6)

demographic information of those admitted to comprehensive psychiatric emergency programs inclusive of age, race, gender and county of residence.

§ 2. This act shall take effect immediately.

PART CC

Section 1. Subdivision 2 of section 493 of the social services law, as added by section 1 of part B of chapter 501 of the laws of 2012, is amended to read as follows:

2. For substantiated reports of abuse or neglect in facilities or provider agencies in receipt of medical assistance and which are no longer subject to amendment or appeal pursuant to section four hundred ninety-four of this article, such information shall also be forwarded by the justice center to the office of the Medicaid inspector general when such abuse or neglect may [~~be relevant to an investigation of unacceptable practices as such practices are defined~~] result in [~~regulations of~~] possible exclusion or other sanction by the office of the Medicaid inspector general as determined in consultation with the office of the Medicaid inspector general.

§ 2. This act shall take effect immediately.

PART DD

Section 1. Section 3 of part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, as amended by section 1 of part T of chapter 57 of the laws of 2021, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART EE

Intentionally Omitted

PART FF

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners of the office of mental health, office for people with developmental disabilities, office of addiction services and supports, office of temporary and disability assistance, office of children and family services, the state office for the aging, the state education department, the department of health, and the director of the office of victim services, shall establish a state fiscal year 2024-2025 cost of living adjustment (COLA), effective April 1, 2024, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in paragraphs (i), (ii), (iii), (iv), (v), (vi), (vii), (viii), and (ix) of subdivision three of this section. The COLA established herein shall be applied to the appropriate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the

department of health (DOH) shall be made as reimbursement for the state share of medical assistance.

2. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefore, for the period of April 1, 2024 through March 31, 2025, the commissioners and directors shall provide funding to support a three and two-tenths percent (3.2%) cost of living adjustment under this section for all eligible programs and services as determined pursuant to subdivision four of this section.

3. 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; community services, and addiction treatment centers.

(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), community action agencies; New York state supportive housing program; solutions to end homelessness program; and state supplemental nutrition assistance program outreach program.

(v) Programs and services funded, licensed, or certified by the office of children and family services (OCFS) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: programs for which the office of children and family services establishes maximum state aid rates pursuant to section 398-a of the social services law and section 4003 of the education law; emergency foster homes; foster family boarding homes and therapeutic foster homes; supervised settings as defined by subdivision twenty-two of section 371 of the social services law; adoptive parents receiving adoption subsidy pursuant to section 453 of the social services law; 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; advantage after-school program; child care resource and referral agencies; empire state after-school program; healthy families New York; maternal, infant, and early childhood home visiting initiative; New York state commission for the blind; residential and non-residential domestic violence services and preventative services as defined by section 409 of the social services law.

(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; supplemental nutrition assistance program; New York connects program; long term ombudsman program; Medicaid transportation program; naturally occurring retirement communities (NORCs); neighborhood naturally occurring retirement communities (NNORCs); and social adult day services program.

(vii) Programs and services funded, licensed, or certified by the state education department eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: community schools; adult literacy education programs; and independent living centers.

(viii) Programs and services funded, licensed, or certified by the office of victim services eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: crime victim service programs as defined by section 631-a of the executive law.

(ix) Programs and services funded, licensed, or certified by the department of health eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: health home care management agencies authorized under section 365-l of the social services law; and rape crisis programs.

4. 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 for purposes eligible under this section. Further, providers shall submit a resolution from their governing body to the appropriate commissioner or director, attesting that the funding received will be used solely to increase the hourly and/or salary wages of non-executive direct care staff, non-executive direct support professionals, and non-executive clinical staff.

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

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

## PART GG

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

29. In the event that the department receives approval from the Centers for Medicare and Medicaid Services to amend its 1115 waiver [~~known as the Partnership Plan~~] or receives approval for a new 1115 waiver [~~for the purpose of reinvesting savings resulting from the redesign of the medical assistance program~~] prior to or following the effec-

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

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

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

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

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

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

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

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

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

## PART HH

Intentionally Omitted

## PART II

Section 1. The public health law is amended by adding a new section 2831 to read as follows:

§ 2831. Medically fragile young adults. 1. For purposes of this section, "medically fragile young adults" shall have the same meaning as the term "medically fragile children" as set forth in subdivision three-a of section thirty-six hundred fourteen of this chapter and shall include medically fragile young adults who currently reside at a pediatric specialized nursing facility and are over twenty-one years of age.

2. The department shall promulgate rules and regulations to allow medically fragile young adults who reside in pediatric specialized nursing facilities to remain at such facilities after reaching the age of twenty-one and until they reach the age of thirty-six. Unless a higher

reimbursement rate is expressly authorized by the department, the reimbursement rate and methodology for such medically fragile young adults shall remain the same as it was prior to reaching age twenty-one and shall include a daily per diem rate and coverage for bed holds. Medicaid reimbursement for this population for reserved beds due to hospitalization and for therapeutic and hospice leaves of absence must remain at one hundred percent of the Medicaid rate of medically fragile children, without any daily limit for this population.

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

PART JJ

Section 1. Paragraph (b) of subdivision 8 of section 2807 of the public health law, as added by section 28 of part B of chapter 1 of the laws of 2002, is amended to read as follows:

(b) For each twelve month period following September thirtieth, two thousand one and continuing through September thirtieth, two thousand twenty-five, the operating cost component of such rates of payment shall reflect the operating cost component in effect on September thirtieth of the prior period as increased by the percentage increase in the Medicare Economic Index as computed in accordance with the requirements of 42 USC § 1396a(aa)(3) and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility. For each twelve month period following September thirtieth, two thousand twenty-five, the operating cost component shall be calculated consistent with rates of payment established pursuant to paragraph (c-1) of this subdivision, and then annually adjusted by using the FQHC Market Basket inflator as calculated pursuant to 42 USC § 1395m(o)(2), and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility.

§ 2. Subdivision 8 of section 2807 of the public health law is amended by adding a new paragraph (c-1) to read as follows:

(c-1) As soon as practicable the department shall analyze the actual federally qualified health center costs filed pursuant to 10 NYCRR 86-4.3 during the prior five year reporting periods. In addition to such data, the commissioner shall consider, the scope of services, including type, intensity, duration and amount, provided by such facilities; staffing to meet competitive market and case mix needs of populations served; physical plant and maintenance costs, infrastructure; technology costs associated with telehealth modality of service delivery; informational technology costs; and other costs deemed necessary by the commissioner. Notwithstanding any other statute, rule, or regulation otherwise imposing ceilings or caps on payments to federally qualified health centers, provided that such payments are still subject to federal financial participation, beginning on April first, two thousand twenty-five, the department shall develop and issue updated rates of payments reflecting the actual costs and updated aggregated data. Prior to implementing the updated rates of payment, the department shall consult with relevant stakeholders including but not limited to the statewide trade association representing such federally qualified health centers for review, revision, and confirmation of the updated rates of payment, as appropriate.

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

PART KK

Section 1. Paragraphs (a), (b), (c) and (d) of subdivision 2-c of section 2808 of the public health law, paragraphs (a), (b) and (c) as added by section 95 of part H of chapter 59 of the laws of 2011, paragraph (d) as amended by section 2 of part M of chapter 57 of the laws of 2022, are amended and new paragraph (b-1) is added to read as follows:

(a) Notwithstanding any inconsistent provision of this section or any other contrary provision of law and subject to the availability of federal financial participation, the non-capital component of rates of payment by governmental agencies for inpatient services provided by residential health care facilities on or after October first, two thousand eleven, but no later than January first, two thousand twelve, shall reflect a direct statewide price component, and indirect statewide price component, and a facility specific non-comparable component, utilizing allowable operating costs for a base year as determined by the commissioner by regulation. Such rate components shall be periodically updated to reflect changes in operating costs**, provided however that such rate components shall be updated no later than January first, two thousand twenty-six and no less frequently than every five years thereafter, using the most currently available cost report data, which updates shall include but not be limited to an update of rate components to reflect actual base year costs**.

(b) The direct and indirect statewide price components shall be adjusted by a wage equalization factor and such other factors as determined to be appropriate to recognize legitimate cost differentials and the direct statewide price component shall be subject to a case mix adjustment utilizing the patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law. Such wage equalization factor **and other factors** shall be periodically updated to reflect current labor market **and other** conditions**, provided however that such updates shall be implemented no later than January first, two thousand twenty-six, and no less frequently than every five years thereafter, based on the most currently available cost report data**.

**(b-1) For purposes of the updates required by paragraphs (a) and (b) of this subdivision and associated changes in the rate-setting methodology, the department shall establish and consult with a technical assistance workgroup that includes external experts with professional expertise in nursing home rate setting.**

(c) The non-capital component of the rates for: (i) AIDS facilities or discrete AIDS units within facilities; (ii) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; (iii) discrete units providing specialized programs for residents requiring behavioral interventions; (iv) discrete units for long-term ventilator dependent residents; and (v) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall reflect the rates in effect for such facilities on January first, two thousand nine, as adjusted for inflation and rate appeals in accordance with applicable statutes, provided, however, that such rates for facilities described in subparagraph (i) of this paragraph shall reflect the application of the provisions of section twelve of part D of chapter fifty-eight of the laws of two thousand nine, and provided further, however, that insofar as such rates reflect trend adjustments for trend factors attributable to the two thousand eight and two thou-

sand nine calendar years the aggregate amount of such trend factor adjustments shall be subject to the provisions of section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended. **Notwithstanding the elimination of a trend factor from rates of payment paid to other residential health care facilities or any other inconsistent provision of law, commencing on and after January first, two thousand twenty-six, the non-capital component of rates established pursuant to this paragraph shall be adjusted for inflation.**

(d) The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision**, including regulations to implement the updates to the rate components and associated changes in the methodology as set forth in paragraphs (a) and (b) 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**, provided however that regulations governing the updates set forth in paragraphs (a) and (b) of this subdivision and associated changes in the methodology may include a transition period as determined by the commissioner in consultation with the stakeholders described in this paragraph and the workgroup set forth in paragraph (b-1) of this subdivision**. 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.

§ 2. This act shall take effect April 1, 2025. 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 date.

PART LL

Section 1. Subdivision 5 of section 4148 of the public health law, as added by chapter 352 of the laws of 2013, is amended to read as follows:

5. Licensed funeral directors and undertakers shall support the establishment and maintenance of the electronic death registration system through a payment, tendered for each burial and removal permit issued to a licensed funeral director or undertaker, in the amount of [~~twenty~~]

five dollars, provided that such payment shall be considered a cost of operation and the funeral director or undertaker shall not charge any additional fee related to such payment for funeral or other services.

§ 2. This act shall take effect April 1, 2025.

PART MM

Section 1. The public health law is amended by adding a new section 2504-c to read as follows:

§ 2504-c. Prenatal and postpartum informational mobile application. 1. The department shall create and operate a New York-tailored, membership-based mobile application for prenatal, pregnant and postpartum individuals.

2. (a) The commissioner is authorized to contract with a mobile developer to create and operate such application on a statewide basis following a competitive bidding process as set forth in the state finance law.

(b) The commissioner, in consultation with the commissioner of mental health, shall include the following application platform deliverables in the request for proposals:

(i) The platform shall have the capability to deliver education, resources and support to prenatal, pregnant and postpartum individuals and their families, including New York-specific information such as links to department and other state agency programs and resources available to prenatal, pregnant and postpartum individuals;

(ii) The platform shall demonstrate a consistent workflow to increase awareness of state agency programs and resources available to users of the mobile application;

(iii) The platform shall allow the department and other state agencies to directly interface with users of the mobile application;

(iv) The platform shall have the capability to allow the department to share specific content and resources with users of the mobile application;

(v) The platform shall include information and resources in the mobile application that, at a minimum, meet the standards set forth in subdivision one of section three hundred sixty-five-k of the social services law; and

(vi) The platform shall be available in multiple languages in accordance with section two hundred two-a of the executive law.

3. The selected mobile developer shall regularly provide the department with aggregate, deidentified data concerning the following:

(a) the number of users of the mobile application that are eligible for Medicaid;

(b) the number of users of the mobile application that are engaging with New York-specific content;

(c) the number of users of the mobile application seeking additional information about enrollment in the Medicaid program or other available resources;

(d) the number of monthly users of the mobile application;

(e) the number of daily users of the mobile application;

(f) the average length of time a user uses the mobile application; and

(g) any other information requested by the department or other state agencies.

4. The mobile application shall be available on multiple mobile platforms.

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

PART NN

Section 1. Subparagraph 4 of paragraph (a) of subdivision 2 of section 366 of the social services law, as amended by section 43 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(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~~] three hundred thousand dollars;

§ 1-a. Subparagraph 4 of paragraph (a) of subdivision 2 of section 366 of the social services law, as amended by section 3 of part AAA of chapter 56 of the laws of 2022, is amended to read as follows:

(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~~] three hundred thousand dollars;

§ 2. Subparagraph 5 of paragraph (c) of subdivision 1 of section 366 of the social services law, as amended by chapter 583 of the laws of 2023, 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 [~~one hundred fifty percent of the income amount permitted under subparagraph seven of paragraph (a) of subdivision two of this section, for a one-person or two-person household~~] three hundred thousand dollars, 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.

§ 3. Subparagraphs 2, 3 and 4 of paragraph (a) of subdivision 2 of section 366 of the social services law are REPEALED.

§ 4. Subparagraphs 5, 6, 7, 9, 10 and 11 of paragraph (a) of subdivision 2 of section 366 of the social services law, subparagraph 5 as amended by chapter 576 of the laws of 2007, subparagraph 6 as amended by chapter 938 of the laws of 1990, subparagraph 7 as amended by section 47 of part C of chapter 58 of the laws of 2008, 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, are renumbered subparagraphs

2, 3, 4, 5, 6 and 7 and clause (iii) of subparagraph 4 is amended to read as follows:

(iii) 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.

§ 4-a. Subparagraphs 5, 6, 7, 8, 9, 10 and 11 of paragraph (a) of subdivision 2 of section 366 of the social services law, as amended by section 3 of part AAA of chapter 56 of the laws of 2022, are renumbered subparagraphs 2, 3, 4, 5, 6, 7 and 8 and subparagraph 5 is amended to read as follows:

(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.

§ 5. Subparagraphs 2, 5 and 10 of paragraph (c) of subdivision 1 of section 366 of the social services law, subparagraphs 2 and 10 as added by section 1 of part D of chapter 56 of the laws of 2013 and subparagraph 5 as amended by section two of this act, are amended to read as follows:

(2) An individual who, although not receiving public assistance or care for [~~his or her~~] **such individual's** 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.

(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 three hundred thousand dollars, 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.

(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.

§ 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, subparagraph 1 as designated and 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 subdivision 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, 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~~] **"the child"** 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 proce-

dures 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~~] **such person**, causing [~~him or her~~] **such person** to exceed the income [~~or resource~~] eligibility level for such assistance;

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

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

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

8. Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, income [~~and resources~~] which [~~are~~] **is** 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~~] **the person's** parent or other legally responsible person.

§ 15. Paragraph (b) of subdivision 16 of section 366 of the social services law, as added by section 1 of part N of chapter 57 of the laws of 2023, is amended to read as follows:

(b) Individuals eligible for participation in such waiver shall:

(i) be a disabled individual, defined as having a medically determinable impairment of sufficient severity and duration to qualify for benefits under Titles II or XVI of the social security act;

(ii) be at least sixteen years of age;

(iii) be otherwise eligible for medical assistance benefits, but for earnings [~~and/or resources~~] in excess of the allowable limit;

(iv) have net available income, determined in accordance with subdivision two of this section, that does not exceed two thousand two hundred fifty percent of the applicable federal poverty line, as defined and updated by the United States department of health and human services;

(v) [~~have resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, other than retirement accounts, that do not exceed three hundred thousand dollars;~~

~~(vi)~~] contribute to the cost of medical assistance provided pursuant to this paragraph in accordance with paragraph (d) of this subdivision; and

[~~(vii)~~] **(vi)** meet such other criteria as may be established by the commissioner as may be necessary to administer the provisions of this subdivision in an equitable manner.

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

sioner of health shall request that the applicant or recipient provide adequate documentation to verify [~~his or her~~] **the applicant's or recipient's** interest income.

§ 17. 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.

§ 18. 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.

§ 19. 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).

§ 20. Subdivisions 5 and 6 of section 366-c of the social services law are REPEALED and subdivisions 7 and 8, as added by chapter 558 of the laws of 1989, are renumbered subdivisions 5 and 6 and 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.~~]

§ 21. The commissioner of health shall, expeditiously and as necessary, submit any state plan amendment or waiver requests necessary to maintain federal financial participation under this act.

§ 22. This act shall take effect April 1, 2025; provided however, that sections one and two of this act shall take effect January 1, 2026; provided, further, however, that sections three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen and twenty of this act shall take effect January 1, 2027; provided, further, however, that if section 3 of part AAA of chapter 56 of the laws of 2022 shall not have taken effect on or before such dates then sections one-a and four-a of this act shall take effect on the same date and in the same manner as such section of such part of such chapter of the laws of 2022, takes effect; provided, further, however, that the amendments to 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, however, that if section 1 of part N of chapter 57 of the laws of 2023 shall not have taken effect on or before such date then section fifteen of this act shall take effect on the same date and in the same manner as such section of such part of such chapter of the laws of 2023, takes effect; provided, further, however, that the effectiveness of sections one through twenty of this act shall be subject to federal financial participation; provided, further, however,

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. 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 OO

Section 1. Paragraph (a) of subdivision 6 of section 3614 of the public health law, as amended by section 4-a of part D of chapter 56 of the laws of 2012, is amended to read as follows:

(a) The commissioner shall, subject to the approval of the state director of the budget, establish capitated rates of payment for services provided by assisted living programs as defined by paragraph (a) of subdivision one of section four hundred sixty-one-l of the social services law. Such rates of payment shall be related to costs incurred by residential health care facilities. The rates shall reflect the wage equalization factor established by the commissioner for residential health care facilities in the region in which the assisted living program is provided and real property capital construction costs associated with the construction of a free-standing assisted living program such rate shall include a payment equal to the cost of interest owed and depreciation costs of such construction. The rates shall also reflect the efficient provision of a quality and quantity of services to patients in such residential health care facilities, with needs comparable to the needs of residents served in such assisted living programs. Such rates of payment shall be equal to fifty percent of the amounts which otherwise would have been expended, based upon the [~~mean prices~~] **costs** for [~~the first of July, nineteen hundred ninety-two (utilizing nineteen hundred eighty-three costs)~~] **two thousand twenty-two or newer** for freestanding[~~, low intensity~~] residential health care facilities with less than three hundred beds[~~, and for years subsequent to nineteen hundred ninety-two,~~] adjusted for inflation in accordance with the provisions of subdivision ten of section twenty-eight hundred seven-c of this chapter, to provide the appropriate level of care for such residents in residential health care facilities in the applicable wage equalization factor regions plus an amount equal to capital construction costs associated with the construction of an assisted living program facility as provided for in this subdivision. **Such rates of payment shall be updated to reflect the most current mean price for free-standing residential health care facilities with less than three hundred beds each time that the cost basis of residential health care facility rates is updated.** The commissioner shall also promulgate regulations, and may promulgate emergency regulations, to provide for reimbursement of the cost of preadmission assessments conducted directly by assisted living programs.

§ 2. This act shall take effect April 1, 2025.

PART PP

Section 1. Clause (xi) of subparagraph 1 of paragraph (e) of subdivision 5 of section 366 of the social services law is REPEALED.

§ 2. The opening paragraph of subparagraph 3 of paragraph (e) of subdivision 5 of section 366 of the social services law, as amended by section 14 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

In determining the medical assistance eligibility of an institutionalized individual, any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for nursing facility services for the period of time specified in subparagraph five of this paragraph. [~~In determining the medical assistance eligibility of a non-institutionalized individual, any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for community based long term care services for the period of time specified in subparagraph five of this paragraph.~~] For purposes of this paragraph:

§ 3. Clause (vi) of subparagraph 1 of paragraph (e) of subdivision 5 of section 366 of the social services law, as amended by section 13 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(vi) "look-back period" means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance[~~, or in the case of a non-institutionalized individual, subject to federal approval, the thirty-month period immediately preceding the date that such non-institutionalized individual applies for medical assistance coverage of long term care services. Nothing herein precludes a review of eligibility for retroactive authorization for medical expenses incurred during the three months prior to the month of application for medical assistance~~].

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

## PART QQ

Section 1. The public health law is amended by adding a new section 4003 to read as follows:

**§ 4003. Director of hospice and palliative care access and quality. 1. The office of hospice and palliative care access and quality is hereby created within the department. The commissioner shall appoint a director of the office and may employ such assistants and personnel as are necessary to carry out the provisions of this article.**

**2. The office shall have the following powers and duties:**

**(a) to provide expertise and input on hospice and palliative care policy development and regulation;**

**(b) to ensure hospice and palliative care providers, workers, and patients are considered when new policy or regulatory changes are contemplated, developed or implemented;**

**(c) to develop recommendations to improve patient care for individuals with chronic or life-limiting illnesses;**

**(d) to facilitate communication between the department and hospice and palliative care providers;**

**(e) to raise awareness and access to hospice and palliative care services;**

**(f) to identify and eliminate barriers to such services;**

**(g) to support models of care and service delivery that would assist in increasing utilization of hospice and palliative care services;**

(h) to work to develop and promote innovative health care delivery models for hospice and palliative care services;

(i) to establish and monitor quality and utilization metrics to promote increased access to high-quality end-of-life care;

(j) to support community-wide efforts to promote advance care planning;

(k) to work in collaboration with the state palliative care education and training council, centers for palliative care excellence, and palliative care practitioner resource centers, to assist in providing education on hospice and palliative care to state, regional, and local personnel;

(l) to ensure equitable access to hospice and palliative care services by underrepresented communities across New York state.

3. The commissioner, in conjunction with the director appointed pursuant to this section, shall prepare and submit a report to the governor, the temporary president of the senate and the speaker of the assembly, and post such report on the department's website, by no later than two years following the effective date of this section and annually thereafter, outlining the activities of the office established pursuant to this section, and recommendations on matters within the scope of the director's duties as set forth in this section.

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

PART RR

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

3. Notwithstanding any provision of law to the contrary, for the state fiscal year beginning April 1, 2024, and thereafter, all department of health Medicaid payments made for services provided on and after April 1, 2024, shall:

(a) be subject to a uniform rate increase of three percent in addition to any other increases contained in this act;

(b) for both inpatient and outpatient services provided by a general hospital, as such term is defined by section 2801 of the public health law, be subject to a uniform rate increase of seven percent in addition to any other increases contained in this act;

(c) for residential health care facilities, as such term is defined by section 2801 of the public health law, be subject to a rate increase of six and one-half percent in addition to any other increases contained in this act;

(d) for assisted living programs, as such term is defined by section 461-l of the social services law, be subject to a rate increase of six and one-half percent in addition to any other increases contained in this act;

(e) for hospice services as such term is defined by section 4002 of the public health law, be subject to a rate increase of six and one-half percent in addition to any other increases contained in this act;

(f) be subject to the approval of the commissioner of health and director of the budget;

(g) be subject to federal financial participation;

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

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

(j) not apply to payments the state is obligated to make pursuant to court orders or judgments;

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

(l) not apply to payments when, at the discretion of the commissioner of health and the director of the budget, 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, 2024.

PART SS

Section 1. Legislative findings and intent. The Legislature affirms the finding of the U.S. Surgeon General's Advisory on Protecting Youth Mental Health that the COVID-19 pandemic has dramatically altered young peoples' experiences at home, at school, and in the community and has exacerbated the unprecedented stresses young people face. The Legislature also finds that there exists an obligation to act to assist our children and their families in this moment of need. The Legislature intends, then, to provide actionable solutions for young people and their families in support of the mental health of children, adolescents, and young adults.

§ 2. Section 5.05 of the mental hygiene law is amended by adding a new subdivision (f) to read as follows:

(f) The commissioners of the office of mental health and the office of addiction services and supports shall establish a youth mental telehealth services program to facilitate access to mental health services, including substance use disorder services, for youth to respond to identified mental health needs, including those needs that may have resulted from the COVID-19 pandemic, and for youth or families that may not have access to mental health professionals in-person. Such program shall provide up to five mental telehealth services annually at no cost to the individual, for acute crisis response, mental health assessment, or initiation of care to reduce barriers and facilitate engagement in long-term care.

The offices shall enter into an agreement with a vendor to create, or use an existing, website or web-based application, as a portal available to youth and providers to facilitate the program no later than November first, two thousand twenty-four. Such vendor shall be determined through a competitive bidding process.

§ 3. This act shall take effect on the one hundred twentieth day after it shall have become a law.

PART TT

Section 1. Article 25-A of the public health law is amended by adding a new section 2599-bb-1 to read as follows:

§ 2599-bb-1. Reproductive freedom and equity grant program. 1. As used in this section, the following terms shall have the following meanings:

(a) "Abortion" shall mean the termination of pregnancy pursuant to section twenty-five hundred ninety-nine-bb of this article.

(b) "Health care services" shall mean the range of care related to the provision of abortion.

(c) "Practical support" shall mean direct assistance to enable a person to obtain abortion care, including but not limited to ground and air transportation, lodging, meals, childcare, translation services, and doula support.

(d) "Program" shall mean the reproductive freedom and equity grant program established pursuant to subdivision two of this section.

2. There is hereby established in the department a reproductive freedom and equity grant program to ensure access to abortion care in the state. The program shall provide funding to abortion providers and non-profit organizations that provide or facilitate access to abortion care. The program shall be designed to provide support to abortion providers and non-profit organizations to increase access to care, fund uncompensated care, and to address the support needs of individuals accessing abortion care. Funding used to support the program shall be subject to appropriation.

3. The commissioner shall distribute funds made available for expenditure under this section. In determining funding for applicants under the grant program, the commissioner shall consider the following criteria and goals:

(a) Increase access to care by growing the capacity of abortion providers to meet present and future care needs. Funds may be awarded to support the recruitment and retention of staff, patient navigators, staff training, the establishment of new or renovation of existing health centers, investments in technology to facilitate care, security enhancements, and other operational or capital needs that increase access to abortion care.

(b) Fund uncompensated health care services associated with abortion care, to ensure the affordability of and access to care for individuals who lack ability to pay for care, for individuals who lack insurance coverage, are underinsured, or whose insurance is deemed unusable by the rendering provider.

(c) Address practical support needs of individuals accessing abortion care for individuals who lack ability to pay for such support.

4. In establishing and operating the program, the commissioner shall consult a range of experts including but not limited to individuals and entities providing abortion care, abortion funds and other organizations whose mission is to expand access to abortion care, to ensure the program structure and expenditures reflect the needs of abortion providers, abortion funds and consumers. The commissioner may make regulations necessary for implementing the program.

5. The commissioner shall not request, or otherwise require, any abortion provider or non-profit organization receiving monies from the program to divulge the name, address, photograph, license number, email address, phone number, or any other individual identifying information of any patient, or individual who sought or received health care services or practical support from an abortion provider or organization under the program.

6. Any non-profit organization or abortion provider receiving funds from the program shall take all necessary steps to ensure the confiden-

tiality of the individuals receiving services pursuant to state and federal laws.

§ 2. Severability clause. If any clause, sentence, paragraph, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid and after exhaustion of all further judicial review, the judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part of this act directly involved in the controversy in which the judgment shall have been rendered.

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

PART UU

Section 1. Direct support wage enhancement. 1. Notwithstanding any other inconsistent provision of law, effective April 1, 2024, providers licensed, funded, approved and/or certified by the office for people with developmental disabilities to provide treatment, services and care for individuals with developmental disabilities shall receive supplemental funding to enhance wages of employees that provide direct care support or any other form of treatment, to individuals with developmental disabilities and whose income is less than seventy-five thousand dollars.

2. The commissioner of the office for people with developmental disabilities, in consultation with the division of the budget, shall establish a list of eligible employee titles for such wage enhancement based on the application of direct care to individuals with intellectual and/or developmental disabilities.

3. Using the forms and processes developed by the commissioner of the office for people with developmental disabilities under this section, employers shall indicate the number of eligible employees based on the list of eligible titles pursuant to subdivision two of this section.

4. The commissioner of the office for people with developmental disabilities shall distribute an allocation to each eligible provider equivalent to two thousand dollars in 2024 per eligible employee based on the forms developed pursuant to subdivision three of this section.

5. Subject to appropriation, the commissioner shall further distribute an allocation to each eligible provider of up to four thousand dollars in 2025 per eligible employee based on the forms developed pursuant to subdivision three of this section.

6. The funds distributed pursuant to this section shall be used to enhance base wages and benefits of eligible employees.

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

PART VV

Section 1. Legislative findings. The legislature acknowledges that doulas face exclusionary measures in gaining recognition and overall integration within the maternal health continuum, such as hospitals and birthing centers. The legislature declares that the purpose of this act is to study and report on the integration of doula care and services in the healthcare continuum and to recommend best practices to designate doula friendly spaces in New York state.

§ 2. The public health law is amended by adding a new section 2803-j-1 to read as follows:

§ 2803-j-1. Designating doula friendly spaces study. 1. The department shall conduct a study to examine and evaluate current practices on the integration of doula care, services, and support within birthing centers, hospitals, and other healthcare delivery facilities. This study shall report such findings through comprehensive metrics on doula friendliness in facilities across the geographic diversity of the state that are licensed under this article. Factors and metrics to be reported by the study shall include but not be limited to:

(a) Identifying and engaging with doula led and centered organizations on their current programs regarding doula integration;

(b) Identifying hospitals and birthing centers that are doula friendly in their operation;

(c) Identifying successful doula integration programs and initiatives in hospitals and birthing centers in New York state; and

(d) Identifying successful doula integration programs and initiatives in other states.

2. The study shall also make recommendations on best practices for the state to help facilitate doula integration and doula friendliness in hospitals and birthing centers. Such recommendations shall include, but not be limited to:

(a) Best practices that doulas currently operating in New York state recommend for proper integration;

(b) Criteria for hospitals and birthing centers for integration of doulas and doula care into the varying processes of birth;

(c) Criteria for how the state should best support the formal designation of doula friendly places;

(d) Criteria for how hospitals and birthing centers shall give doulas visitor status or equal status in the facilities;

(e) Criteria for doula presence in the birthing room;

(f) Criteria for inclusion of doulas in the healthcare continuum;

(g) Best practices and criteria for the collection of data regarding doula friendliness and integration; and

(h) Best practices for the reporting of metrics for doula friendliness and integration.

3. On or before December thirty-first, two thousand twenty-five, the department shall submit a final report containing all findings and recommendations to the governor, the temporary president of the senate, and the speaker of the assembly.

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

PART WW

Section 1. Legislative findings. The legislature hereby declares that poor maternal and infant health outcomes, especially when it comes to racial disparities, are a public health crisis that pose a threat to the health, welfare, and quality of life of child bearing people, infants and their families. The legislature hereby acknowledges that community-based doula care is one solution in addressing this public health crisis. The legislature also acknowledges imbalances in how doula care is accessed in different communities. The legislature also acknowledges how doulas in the BIPOC community are integrated, or lack integration into the maternal health continuum. The legislature acknowledges that those seeking to become community-based doulas face a multitude of barriers, including institutional barriers, within the healthcare continuum. The legislature hereby finds the importance in establishing a

dedicated fund to support community-based doulas and community-based doula organizations. This fund would be assisting those trying to navigate the Federal and State Medicaid frameworks for doula care to become community-based doulas. Which would be one step in solving the existing barriers to those seeking equitable prenatal, intranatal, and postpartum care services.

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

**TITLE III-A**

**COMMUNITY DOULA EXPANSION PROGRAM**

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

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

**§ 2561. Definitions. As used in this title:**

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

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

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

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

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

**4. The commissioner shall create and maintain an awareness and outreach program. The awareness and outreach program shall be established for the purpose of providing education and awareness of the available grants and funds to eligible providers in the state.**

**§ 2563. Report. The commissioner shall establish a comprehensive list of reporting metrics to be included in a report due on December thirty-first, two thousand twenty-six and annually thereafter, to the governor, to the temporary president of the senate, and to the speaker of the assembly. The report shall include the comprehensive list of reporting metrics and shall include, but not be limited to, the total amount of grants issued, the number of eligible providers, and the region of the state where the eligible provider is located.**

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

§ 99-rr. Community doula expansion grant program fund. 1. There is hereby established in the joint custody of the state comptroller and commissioner of taxation and finance a special fund to be known as the "Community doula expansion grant program fund".

2. Such fund shall consist of all monies appropriated thereto from any other fund or source pursuant to law. Nothing contained in this section shall prevent the state from receiving grants, gifts or bequests for the purposes of the fund as defined in this section and depositing them into the fund according to law.

3. Monies shall be payable from the fund on the audit and warrant of the comptroller on vouchers approved and certified by the commissioner of health.

4. The monies in such fund shall be expended for the community doula expansion grant program in accordance with the provisions of section twenty-five hundred sixty-two of the public health law.

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

PART XX

Section 1. Short title. This act shall be known and may be cited as the "hospital medical debt relief act".

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

TITLE 3-A

HOSPITAL MEDICAL DEBT RELIEF PROGRAM

Section 245. Definitions.

246. Hospital medical debt relief program.

§ 245. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Eligible resident" means an individual that meets the following conditions:

(a) is a resident of the state;

(b) has a household income at or below four hundred percent of the federal poverty guidelines or has hospital-based medical debt equal to five percent or more of the individual's household income; and

(c) has had hospital medical debt relieved under this program.

2. "General hospital medical debt" means an obligation or an alleged obligation of an eligible resident to pay any amount whatsoever related to the receipt of health care services, products, or devices provided to a person by a general hospital licensed under article twenty-eight of the public health law or a health care professional authorized under title eight of the education law who practices within a hospital, whether or not such obligation has been reduced to judgment.

§ 246. Hospital medical debt relief program. 1. The commissioner, subject to general fund appropriations for this purpose, shall establish a three-year pilot program to provide hospital medical debt relief to eligible residents in the state.

2. Pursuant to sections one hundred twelve and one hundred sixty-three of the state finance law, the commissioner shall contract with a not-for-profit organization to identify and cancel the hospital medical debt owed by eligible residents to hospitals and their contracted providers located within the state, to the extent possible. Such not-for-profit organization shall enter into agreements with general hospitals in the state to identify eligible residents utilizing patient data provided by such participating hospitals including, demographic information, resi-

dents' zip codes, insurance status and payer, dates of service, balances still owed, and other information necessary to identify an eligible resident. The not-for-profit organization shall retire such eligible residents' hospital medical debt by acquiring such debt through purchase or receipt as a donation from a participating general hospital and then cancelling such debt. Any such purchase of hospital medical debt shall be for an amount at or below the fair market value of such debt. All data sharing shall comply with the provisions of the federal health insurance portability and accountability act and any other applicable state or federal law.

3. To the extent possible, for general hospitals that have entered into an agreement under the program, priority shall be given: (a) to eligible residents whose debt is eighteen months or older; and/or (b) who resides in the lowest-income zip codes.

4. The not-for-profit organization shall also notify each eligible resident who has had a debt cancelled pursuant to the provisions of this section that their specific hospital medical debt has been cancelled and that the debt cancelation does not lead to income tax liabilities for program recipients. Such notice shall include a copy of the hospital's financial assistance application and policy pursuant to section twenty-eight hundred of this chapter.

5. Once a hospital medical debt has been cancelled, the participating general hospital or their third party agent, that reported the hospital medical debt to the credit reporting agencies, shall inform the credit reporting agencies of such cancellation to ensure that the debt has been removed from an eligible recipient's credit report.

6. The not-for-profit organization shall conduct an outreach program to have discussions with general hospitals about the benefits of the hospital medical debt relief program to patients, communities and to the hospitals themselves. Such outreach shall first be initiated with enhanced safety net hospitals as defined in section twenty-eight hundred seven-c of this chapter.

7. The not-for-profit organization shall, in consultation with the department report annually on the progress and success of the hospital medical debt relief program established pursuant to this section to the governor and the temporary president of the senate, the speaker of the assembly, the department, and the chair of the senate committee on health and the chair of the assembly committee on health. Such report shall be published and publicly available on the department's website. Such report shall include but not be limited to:

(a) the amount of hospital medical debt purchased and discharged under the program;

(b) the number of eligible residents who received relief under the program;

(c) to the extent practicable the characteristics of the eligible residents;

(d) the number of individual debts purchased;

(e) total number of eligible residents by zip code;

(f) the number of individual debts purchased by zip code;

(g) the number of individual debts canceled by county separated by 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, as follows: (i) two hundred percent and below, (ii) above two hundred percent up to three hundred percent, (iii) above three hundred percent up to four hundred percent, (iv) above four hundred percent; and

(h) any other data or information requested by the department and that can be included pursuant to applicable laws and regulations and within budgeted resources.

8. The commissioner shall promulgate any rules and regulations necessary for the implementation of this section.

§ 3. Subsection (i) of section 601 of the tax law is relettered subsection (j) and a new subsection (i) is added to read as follows:

(i) Hospital medical debt relief. Notwithstanding the provisions of subsections (a), (b), (c) and (d) of this section and any other provision of this article, for taxable years beginning after the effective date of this subsection, the income of an individual received pursuant to the provisions of section two hundred forty-six of the public health law in the form of debt cancelation shall be exempt from tax under this article regardless of whether such income is subject to federal income taxation.

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

PART YY

Section 1. Subparagraph 10 of paragraph (a) of subdivision 2 of section 366 of the social services law, as added by chapter 705 of the laws of 1988, clauses (i) and (ii) as amended by chapter 672 of the laws of 2019, and clause (iii) as amended by chapter 170 of the laws of 1994, is amended to read as follows:

(10) (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~~] one hundred forty 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~~] eighty-nine 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~~] one hundred twenty-eight 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~~] eighty-nine 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~~] **one hundred ninety-six** dollars per month.

§ 2. Subparagraph 10 of paragraph (a) of subdivision 2 of section 366 of the social services law, as amended by section 3 of part AAA of chapter 56 of the laws of 2022, is amended to read as follows:

(10) (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~~] **one hundred forty** 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~~] **eighty-nine** 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~~] **one hundred twenty-eight** 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~~] **eighty-nine** 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~~] **one hundred ninety-six** dollars per month.

§ 3. This act shall take effect January 1, 2025 and shall apply to all benefits and allowances issued on and after such date; provided, however, that section two of this act shall take effect on the same date and in the same manner as section 3 of part AAA of chapter 56 of the laws of 2022, takes effect.

PART ZZ

Section 1. The mental hygiene law is amended by adding a new section 19.46 to read as follows:

**§ 19.46 Drug checking services program.**

**1. The office of addiction services and supports shall contract with a vendor to establish a program to provide drug checking services to assist individuals in determining whether a drug or controlled substance contains contaminants, toxic substances, or hazardous compounds following a competitive bidding process as set forth in the state finance law.**

2. In providing drug checking services, the authorized vendor shall:

(a) provide information and harm reduction advice to help individuals make informed decisions about drug use;

(b) test any drug or substance that an individual presents for checking to ascertain the composition and likely identity of such drug or substance;

(c) advise the individual who presented a drug or substance for checking of the results of the testing;

(d) return the drug or substance to the individual who presented such drug or substance for checking;

(e) dispose of or arrange for the disposal of, any sample of a drug or substance used in testing and any drug or substance surrendered by any individual for disposal; and

(f) if necessary, arrange for a sample of a drug or substance to be tested by a department approved laboratory.

3. The authorized vendor shall acquire the necessary equipment to provide drug checking services, including but not limited to, chemical screening devices such as infrared spectrophotometers, mass spectrometers, nuclear magnetic resonance spectrometers, raman spectrophotometers, or ion mobility spectrometers.

4. Employees, contractors, and volunteers of the authorized vendor, directors, managers, employees, contractors, and volunteers of an organization providing drug checking services, owners of properties where drug checking services occur, and individuals presenting drugs or substances for checking, acting in the course and scope of employment or engaged in good faith in the provision of drug checking services, in accordance with established protocols, shall not be subject to:

(a) arrest, charges, or prosecution pursuant to this article or any violation or misdemeanor, including for attempting, aiding and abetting, or conspiracy to commit a violation or misdemeanor pursuant to article two hundred twenty of the penal law; or

(b) a civil or administrative penalty or liability of any kind, or disciplinary action by a professional licensing board, for conduct relating to the provision of drug checking services unless such conduct was performed in a negligent manner or in bad faith.

5. The authorized vendor shall not collect, maintain, use, or disclose any personal information relating to an individual from whom the vendor receives any drug or substance for checking or disposal.

6. The result of any test carried out by the authorized vendor in relation to any drug or substance presented for checking shall not be admissible as evidence in any criminal or civil proceedings against the individual from whom the drug or substance was received, unless submitted by such individual.

§ 2. This act shall take effect April 1, 2025. 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 AAA

Section 1. Section 30-a of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

§ 30-a. Definitions. For the purposes of this title, the following definitions shall apply:

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost

to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

2. "Creditable allegation of fraud" (a) means an allegation which has been verified by the inspector, from any source, including but not limited to the following:

i. fraud hotlines tips verified by further evidence;

ii. claims data mining; and

iii. patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

(b) allegations are considered to be credible when they have an indicia of reliability and the inspector has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

3. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable federal or state law.

4. "Inspector" means the Medicaid inspector general created by this title.

[~~2.~~] 5. "Investigation" means investigations of fraud, abuse, or illegal acts perpetrated within the medical assistance program, by providers or recipients of medical assistance care, services and supplies.

6. "Medical assistance," "Medicaid," and "recipient" shall have the same meaning as those terms in title eleven of article five of the social services law and shall include any payments to providers under any Medicaid managed care program.

[~~3.~~] 7. "Office" means the office of the Medicaid inspector general created by this title.

8. "Overpayment" shall mean any amount paid to a provider for medical assistance in excess of the amount allowable for services furnished under section nineteen hundred two of the federal social security act and which is required to be refunded under section nineteen hundred three of such act.

9. "Provider" means any person or entity enrolled as a provider in the medical assistance program.

§ 2. Subdivision 20 of section 32 of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

20. to, consistent with [~~provisions of~~] this title and applicable federal laws, regulations, policies, guidelines and standards, implement and amend, as needed, rules and regulations relating to the prevention, detection, investigation and referral of fraud and abuse within the medical assistance program and the recovery of improperly expended medical assistance program funds;

§ 3. The public health law is amended by adding two new sections 37 and 38 to read as follows:

§ 37. Audit and recovery of medical assistance payments to providers. Any audit or review of any provider contracts, cost reports, claims, bills, or medical assistance payments by the inspector, anyone designated by the inspector or otherwise lawfully authorized to conduct such audit or review, or any other agency with jurisdiction to conduct such audit or review, shall comply with the following standards:

1. Recovery of any overpayment resulting from any audit or review of provider contracts, cost reports, claims, bills, or medical assistance payments shall not commence prior to sixty days after delivery to the

provider of a final audit report or final notice of agency action, or where the provider requests a hearing or appeal within sixty days of delivery of the final audit report or final notice of agency action, until a final determination of such hearing or appeal is made.

2. Provider contracts, cost reports, claims, bills or medical assistance payments that were the subject matter of a previous audit or review within the last three years shall not be subject to review or audit again except on the basis of new information, for good cause to believe that the previous review or audit was erroneous, or where the scope of the inspector's review or audit is significantly different from the scope of the previous review or audit.

3. Any reviews or audits of provider contracts, cost reports, claims, bills or medical assistance payments shall apply the state laws, regulations and the applicable, duly promulgated policies, guidelines, standards, protocols and interpretations of state agencies with jurisdiction and in effect at the time the provider engaged in the applicable regulated conduct or provision of services. For the purpose of this subdivision, the state law, regulation or the applicable promulgated agency policy, guideline, standard, protocol or interpretation shall not be deemed in effect if federal governmental approval is pending or denied. The inspector shall publish protocols applicable to and governing any audit or review of a provider or provider contracts, cost reports, claims, bills or medical assistance payments on the office of Medicaid inspector general website.

4. (a) In the event of any overpayment based upon a provider's administrative or technical error, the provider shall have the longer of sixty days from notice of the mistake or six years from the date of service to submit a corrected claim provided (i) the error was a genuine error without intent to falsify or defraud, (ii) the provider maintained contemporaneous documentation to substantiate the correct claims information, (iii) such error is the sole basis for the finding of an overpayment, and (iv) there is no finding of any overpayment for such error by a federal agency or official.

(b) No overpayment shall be calculated for any administrative or technical error corrected as required in paragraph (a) of this subdivision.

(c) "Administrative or technical error" shall include any error that constitutes either a (i) minor error or omission or (ii) clerical error or omission under the Medicare modernization act or centers for Medicaid and Medicaid service regulations, and shall include human and clerical errors that result in errors as to form or content of a claim.

5. (a) In determining the amount of any overpayment to a provider, the inspector shall utilize sampling and extrapolation consistent with the Centers for Medicare and Medicaid services policies as described in the Centers for Medicare and Medicaid program integrity manual.

(b) The final audit report or final notice of agency action shall include a statement of the specific factual and legal basis for utilizing extrapolation and the inappropriate use of extrapolation shall be a basis for appeal. This subdivision shall not be construed to limit the recoupment of an overpayment identified without the use of extrapolation.

(c) Until the provider has waived its right to a hearing, or if a provider requests a hearing, until the hearing determination is issued, the provider shall have the right to pay the lower confidence limit plus applicable interest in fulfillment of this paragraph, the applicable lower confidence limit shall be calculated using at least a ninety percent confidence level.

6. (a) The provider shall be provided as part of the draft audit findings a detailed written explanation of the extrapolation method employed, including the size of the sample, the sampling methodology, the defined universe of claims, the specific claims included in the sample, the results of the sample, the assumptions made about the accuracy and reliability of the sample and the level of confidence in the sample results, and the steps undertaken and statistical methodology utilized to calculate the alleged overpayment and any applicable offset based on the sample results. This written information shall include a description of the sampling and extrapolation methodology.

(b) The sampling and extrapolation methodologies utilized by the inspector shall be consistent with accepted standards of sound auditing practice and statistical analysis.

7. The requirements of this section shall be interpreted consistent with and subject to any applicable federal law, rules and regulations, or binding federal agency guidance and directives. The requirements of this section shall not apply to any investigation by the inspector where there is credible allegations of fraud or where there is a finding that the provider has engaged in deliberate abuse of the medical assistance program.

§ 38. Procedures, practices and standards for recipients. 1. This section applies to any adjustment or recovery of a medical assistance payment from a recipient, and any investigation or other proceeding relating thereto.

2. At least five business days prior to commencement of any interview with a recipient as part of an investigation, the inspector or other investigating entity shall provide the recipient with written notice of the investigation. The notice of the investigation shall set forth the basis for the investigation; the potential for referral for criminal investigation; the individual's right to be accompanied by a relative, friend, advocate or attorney during questioning; contact information for local legal services offices; the individual's right to decline to be interviewed or participate in an interview but terminate the questioning at any time without loss of benefits; and the right to a fair hearing in the event that the investigation results in a determination of incorrect payment.

3. Following completion of the investigation and at least thirty days prior to commencing a recovery or adjustment action or requesting voluntary repayment, the inspector or other investigating entity shall provide the recipient with written notice of the determination of incorrect payment to be recovered or adjusted. The notice of determination shall identify the evidence relied upon, set forth the factual conclusions of the investigation, and explain the recipient's right to request a fair hearing in order to contest the outcome of the investigation. The explanation of the right to a fair hearing shall conform to the requirements of subdivision twelve of section twenty-two of the social services law and regulations thereunder.

4. A fair hearing under section twenty-two of the social services law shall be available to any recipient who receives a notice of determination under subdivision three of this section, regardless of whether the recipient is still enrolled in the medical assistance program.

§ 4. Paragraph (c) of subdivision 3 of section 363-d of the social services law, as amended by section 4 of part V of chapter 57 of the laws of 2019, is amended and a new subdivision 8 is added to read as follows:

(c) In the event that the commissioner of health or the Medicaid inspector general finds that the provider does not have a satisfactory program [~~within ninety days after the effective date of the regulations issued pursuant to subdivision four of this section~~], the commissioner or Medicaid inspector general shall so notify the provider, including specification of the basis of the finding sufficient to enable the provider to adopt a satisfactory compliance program. The provider shall submit to the commissioner or Medicaid inspector general a proposed satisfactory compliance program within sixty days of the notice and shall adopt the program as expeditiously as possible. If the provider does not propose and adopt a satisfactory program in such time period, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

8. Any regulation, determination or finding of the commissioner or the Medicaid inspector general relating to a compliance program under this section shall be subject to and consistent with subdivision three of this section.

§ 5. Section 32 of the public health law is amended by adding a new subdivision 6-b to read as follows:

6-b. to consult with the commissioner on the preparation of an annual report, to be made and filed by the commissioner on or before the first day of July to the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate, the minority leader of the assembly, the commissioner, the commissioner of the office of addiction services and supports, and the commissioner of the office of mental health on the impacts that all civil and administrative enforcement actions taken under subdivision six of this section in the previous calendar year will have and have had on the quality and availability of medical care and services, the best interests of both the medical assistance program and its recipients, and fiscal solvency of the providers who were subject to the civil or administrative enforcement action;

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

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

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