STATE OF NEW YORK

3007--B

IN SENATE

January 22, 2025

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 part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, in relation to extending the expiration thereof; to amend chapter 942 of the laws of 1983 and chapter 541 of the laws of 1984 relating to foster family care demonstration programs, in relation to extending the expirations thereof; to amend chapter 256 of the laws of 1985, amending the social services law and other laws relating to foster family care demonstration programs, in relation to extending the expiration thereof; to amend part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to the effectiveness thereof; to amend the public health law, in relation to extending certain mobile integrated and community paramedicine programs; to amend section 2 of chapter 137 of the laws of 2023, amending the public health law relating to establishing a community-based paramedicine demonstration program, in relation to extending the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to extending the effectiveness of certain provisions thereof; to amend part FFF of chapter 59 of the laws of 2018, amending the public health law relating to authorizing the commissioner of health to redeploy excess reserves of certain not-for-profit managed care organizations, in relation to the effectiveness thereof; to amend chapter 451 of the laws of 2007, amending the public health law, the social services law

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

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and the insurance law relating to providing enhanced consumer and provider protections, in relation to the effectiveness of certain provisions relating to contracts between plans, insurers, or corporations and hospitals; to amend the public health law, in relation to reimbursement rate promulgation for residential health care facilities, and in relation to certified home health agency services payments; to amend part C of chapter 60 of the laws of 2014, amending the social services law relating to fair hearings within the Fully Integrated Duals Advantage program, in relation to the effectiveness thereof; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness of certain provisions thereof; to amend part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services; to amend the public health law, in relation to gross receipts for general hospital assessments; to amend part MM of chapter 57 of the laws of 2021 amending the public health law relating to aiding in the transition to adulthood for children with medical fragility living in pediatric nursing homes and other settings, in relation to the effectiveness thereof; to amend chapter 633 of the laws of 2006, amending the public health law relating to the home based primary care for the elderly demonstration project, in relation to the effectiveness thereof; to amend chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, in relation to the effectiveness thereof; to amend part BBB of chapter 56 of the laws of 2022, amending the public health law and other laws relating to permitting the commissioner of health to submit a waiver that expands eligibility for New York's basic health program and increases the federal poverty limit cap for basic health program eligibility from two hundred to two hundred fifty percent, in relation to extending certain provisions related to providing long-term services and supports under the essential plan; to amend the social services law, in relation to which contracts stay in force after September 30, 2025; and to amend part MM of chapter 56 of the laws of 2020 directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, in relation to which contracts stay in force after September 30, 2025 (Part B); intentionally omitted (Part C); to amend the public health law, in relation to supplemental hospital payments (Part D); to amend the social services law, in relation to shifting long-term nursing home stays from managed care to fee for service, and authorizing penalties for managed care plans that do not meet contractual obligations (Part E); to amend the public health law, in relation to establishing a tax on managed care providers; to amend the state finance law, in relation to the healthcare stability fund; to amend part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, in relation to certain Medicaid payments made for certain medical services; and to amend the public health law, in

relation to federally qualified health center rate adequacy and general hospital inpatient reimbursement (Part F); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending the 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 G); intentionally omitted (Part H); to amend the public health law, in relation to eliminating the fees paid by funeral directors for permits for burials and removals which are used to support the electronic death registration system; and to repeal certain provisions of such law relating thereto (Part I); to amend the public health law, in relation to the due date for awards applied for under the statewide health care facility transformation III program (Part J); to amend the public health law, in relation to appointing a temporary operator for general hospitals, diagnostic and treatment centers, and adult care facilities (Part K); intentionally omitted (Part L); to amend the public health law, in relation to requiring general hospitals to report community benefit spending (Part M); to amend the public health law, in relation to expanding the purposes of the spinal cord injury research board; and to amend the state finance law, in relation to the spinal cord injury research trust fund (Part N); to amend the public health law, in relation to authorizing institutional dispensers to dispense controlled substances for use off premises in an emergency situation for at least three days; to amend the judiciary law, the mental hygiene law, the public health law, the county law, and the general city law, in relation to replacing the words addict and addicts with the words person with substance use disorder or variation thereof; and to amend the public health law, in relation to dispensing certain controlled substances for use by a person with a substance use disorder (Part O); to amend the public health law, in relation to requiring hospitals to provide stabilizing care to pregnant individuals; and to repeal section 2803-o-1 of the public health law, relating to required protocols for fetal demise (Part P); to amend the social services law and the public health law, in relation to establishing increased coverage of care as well as availability of care for infertility treatments; and to repeal section 4 of part K of chapter 82 of the laws of 2002 amending the insurance law and the public health law relating to coverage for the diagnosis and treatment of infertility, relating to the establishment of a program to provide grants to health care providers for improving access to infertility services; and directing the department of health to establish an alternative payment methodology (APM) for federally qualified health centers to preserve and improve patient access to fertility care (Part Q); to amend the general municipal law and the public health law, in relation to emergency medical services (Part R); to amend the public health law, in relation to strengthening material transactions reporting requirements (Part S); to amend the public health law and the executive law, in relation to requiring hospitals to maintain sexual assault forensic examiners at their facilities (Part T); intentionally

omitted (Part U); intentionally omitted (Part V); intentionally omitted (Part W); intentionally omitted (Part X); to amend the public health law, in relation to extending hospital services outside the facility and into patients' residences; and providing for the repeal of such provisions upon expiration thereof (Part Y); to amend chapter 565 of the laws of 2022 amending the state finance law relating to preferred source status for entities that provide employment to certain persons, in relation to the effectiveness thereof; and to amend chapter 91 of the laws of 2023 amending the state finance law relating to establishing a threshold for the amount of work needed to be performed by a preferred source which is an approved charitable non-profit-making agency for the blind, in relation to the effectiveness thereof (Part Z); 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 AA); to amend part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence, in relation to the effectiveness thereof (Part BB); to amend part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, in relation to the effectiveness of certain provisions thereof (Part CC); to amend the mental hygiene law and the public health law, in relation to adding homeless youth to the definition of minors for the purpose of consent for certain treatment, and clarifying that behavioral health services includes mental health and substance use treatment (Part DD); to amend the mental hygiene law, in relation to community provider notice of admission and involvement in release of certain persons in in-patient facilities (Part EE); in relation to establishing a targeted inflationary increase for designated human services programs (Part FF); to amend the social services law, in relation to reimbursement for early and periodic screening, diagnosis and treatment (Part GG); to amend the public health law, in relation to the functions of the Medicaid inspector general with respect to audit and review of medical assistance program funds (Part HH); to amend the public health law and the insurance law, in relation to providing information to patients and the public on hospital rule-based exclusions (Part II); to amend the public health law, in relation to establishing the "Sickle Cell Treatment Act" (Part JJ); to amend the public health law, in relation to preserving access to affordable drugs (Part KK); to amend the mental hygiene law, in relation to establishing the statewide emergency and crisis response council to plan and provide support regarding the operation and financing of high-quality emergency and crisis response services for persons experiencing a mental health, alcohol use, or substance use crisis (Part LL); to amend the public health law, in relation to reporting pregnancy losses and clarifying which agencies are responsible for such reports; and providing for the repeal of certain provisions upon expiration thereof (Part MM); to amend the public health law, in relation to enacting the New York state abortion clinical training program act (Part NN); to amend the insurance law and the social services law, in relation to primary care investment

(Part OO); to amend the social services law, in relation to including services provided by certified recovery peer advocates and certain services provided at inpatient facilities as part of standard coverage (Part PP); to amend the public health law, in relation to establishing a drug checking program including requirements for enhanced drug checking service delivery and public health surveillance (Part QQ); to amend the public health law, in relation to a review and recommendations of reimbursement adequacy and other matters relating to early intervention (Part RR); to amend the social services law, in relation to authorizing licensed creative arts therapists to bill Medicaid directly for their services (Part SS); to amend the public health law, in relation to establishing an office of the state medical indemnity fund ombudsperson and a medical indemnity fund advisory panel (Part TT); to amend the public health law, in relation to expanding health care services provided by telehealth; and to amend 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 (Part UU); to amend the social services law, in relation to coverage for services provided by school-based health centers for medical assistance recipients (Part VV); to amend the social services law, in relation to including dental implants, replacement dental prosthetic appliances, crowns and root canals as medically necessary dental care and services for coverage under the Medicaid program (Part WW); to amend chapter 769 of the laws of 2023, amending the public health law relating to the adult cystic fibrosis assistance program, in relation to the effectiveness thereof (Part XX); to amend the public health law, in relation to expanding the Doctors Across New York program to include dentists (Part YY); to amend the social services law, in relation to increasing the amount of the savings exemption for eligibility for Medicaid (Part ZZ); to amend the public health law, in relation to requiring annual reports on tick-borne illnesses; and to require the superintendent of financial services to review the status of health insurance coverage for the treatment of Lyme disease and other tick-borne related diseases (Part AAA); 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 BBB); to amend part KK of chapter 57 of the laws of 2024 amending the public health law relating to the creation of a community doula expansion grant program, and repealing such program upon expiration thereof, in relation to removing the expiration of such provisions (Part CCC); to amend the mental hygiene law, in relation to funds received pursuant to a New York opioid settlement sharing agreement; to amend the state finance law, in relation to the opioid stewardship fund (Part DDD); to amend the public health law, in relation to minimum direct resident care spending by residential health care facilities (Part EEE); to amend the public health law, in relation to managed long term care plans (Part FFF); and to amend the public health law, in relation to establishing the upstate CINERGY demonstration program (Part GGG)

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 2025-2026 state fiscal year. Each component is wholly contained within a Part identified as Parts A through GGG. 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 1-a of section 60 of part B of chapter 57 of the laws of 2015, amending the social services law and other laws relating to supplemental rebates, as amended by section 10 of part BB of chapter 56 of the laws of 2020, is amended to read as follows:

1-a. section fifty-two of this act shall expire and be deemed repealed March 31, [~~2025~~] 2030;

§ 2. Section 3 of chapter 942 of the laws of 1983, relating to foster family care demonstration programs, as amended by chapter 264 of the laws of 2021, is amended to read as follows:

§ 3. This act shall take effect immediately and shall expire December 31, [~~2025~~] 2027.

§ 3. Section 3 of chapter 541 of the laws of 1984, relating to foster family care demonstration programs, as amended by chapter 264 of the laws of 2021, is amended to read as follows:

§ 3. This section and subdivision two of section two of this act shall take effect immediately and the remaining provisions of this act shall take effect on the one hundred twentieth day next thereafter. This act shall expire December 31, [~~2025~~] 2027.

§ 4. Section 6 of chapter 256 of the laws of 1985, amending the social services law and other laws relating to foster family care demonstration programs, as amended by chapter 264 of the laws of 2021, is amended to read as follows:

§ 6. This act shall take effect immediately and shall expire December 31, [~~2025~~] 2027 and upon such date the provisions of this act shall be deemed to be repealed.

§ 5. Intentionally omitted.

§ 6. Subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, as amended by section 2 of part CC of chapter 57 of the laws of 2022, is amended to read as follows:

(f) section twenty-five of this act shall expire and be deemed repealed April 1, [~~2025~~] 2028;

§ 7. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to

rates for residential healthcare facilities, as amended by section 4 of part CC of chapter 57 of the laws of 2022, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, and for the state fiscal year beginning April 1, 2016 through March 31, 2019, and for the state fiscal year beginning April 1, 2019 through March 31, 2022, and for the state fiscal year beginning April 1, 2022 through March 31, 2025, **and for the state fiscal year beginning April 1, 2025 through March 31, 2028,** the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state

fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

§ 8. Subdivision 3 of section 3018 of the public health law, as added by chapter 137 of the laws of 2023, is amended to read as follows:

3. This program shall authorize mobile integrated and community paramedicine programs presently operating and approved by the department as of May eleventh, two thousand twenty-three, under the authority of Executive Order Number 4 of two thousand twenty-one, entitled "Declaring a Statewide Disaster Emergency Due to Healthcare staffing shortages in the State of New York" to continue in the same manner and capacity as currently approved for a period of [~~two~~] **four** years following the effective date of this section.

§ 8-a. Section 2 of chapter 137 of the laws of 2023, amending the public health law relating to establishing a community-based paramedicine demonstration program, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed [~~2~~] **4** years after such date; provided, however, that if this act shall have become a law on or after May 22, 2023 this act shall take effect immediately and shall be deemed to have been in full force and effect on and after May 22, 2023.

§ 9. Subdivision 12 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by chapter 161 of the laws of 2023, is amended to read as follows:

12. Sections one hundred five-b through one hundred five-f of this act shall expire June 30, [~~2025~~] **2027**.

§ 10. Section 2 of subpart B of part FFF of chapter 59 of the laws of 2018, amending the public health law relating to authorizing the commissioner of health to redeploy excess reserves of certain not-for-profit managed care organizations, as amended by chapter 197 of the laws of 2023, is amended to read as follows:

§ 2. This act shall take effect August 1, 2018 and shall expire and be deemed repealed August 1, [~~2025~~] **2027**, but, shall not apply to any entity or any subsidiary or affiliate of such entity that disposes of all or a material portion of its assets pursuant to a transaction that: (1) was the subject of a request for regulatory approval first made to the commissioner of health between January 1, 2017, and December 31, 2017; and (2) receives regulatory approval from the commissioner of health prior to July 31, 2018.

§ 11. Subdivision 1 of section 20 of chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law relating to providing enhanced consumer and provider protections, as amended by section 1 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

1. sections four, eleven and thirteen of this act shall take effect immediately and shall expire and be deemed repealed June 30, [~~2025~~] **2027**;

§ 12. Paragraph (b) of subdivision 17 of section 2808 of the public health law, as amended by section 12 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal years beginning April first, two thousand ten and ending March thirty-first, two thousand [~~twenty-five~~] twenty-seven, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand [~~twenty-five~~] twenty-seven, based on consideration of rate appeals filed by residential health care facilities or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for each such state fiscal year provided, however, that for the period April first, two thousand eleven through March thirty-first, two thousand twelve such aggregate annual amount shall be fifty million dollars. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such other considerations as the commissioner deems appropriate and, further, the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; provided, however, that the commissioner's authority to negotiate such agreements resolving multiple pending rate appeals as hereinbefore described shall continue on and after April first, two thousand [~~twenty-five~~] twenty-seven. Rate adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

§ 13. Paragraph (a) of subdivision 13 of section 3614 of the public health law, as amended by section 13 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective April first, two thousand twelve through March thirty-first, two thousand [~~twenty-five~~] twenty-seven, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discreet groups as may be determined by the commissioner pursuant to regulations, shall be based on episodic payments. In establishing such payments, a statewide base price shall be established for each sixty day episode of care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

§ 14. Subdivision 4-a of section 71 of part C of chapter 60 of the laws of 2014, amending the social services law relating to fair hearings within the Fully Integrated Duals Advantage program, as amended by section 27 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

4-a. section twenty-two of this act shall take effect April 1, 2014, and shall be deemed expired January 1, [~~2026~~] **2028**;

§ 15. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 29 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

§ 11. This act shall take effect immediately and:

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

(b) sections four through ten shall expire on June 30, [~~2025~~] **2027**, and

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

§ 16. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 30 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023, and on and after April 1, 2023 through March 31, 2025**, and on and after April 1, 2025 through March 31, 2027**;

§ 17. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 31 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

§ 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023, and on and after April 1, 2023 through March 31, 2025**, and on and after April 1, 2025 through March 31, 2027**.

§ 18. Section 4-a of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 32 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2017 through March 31, [~~2025~~] 2027, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024 [~~and~~], 2025, 2026 and 2027 calendar years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024 [~~and~~], 2025, 2026 and 2027 calendar years shall also be applied to rates of payment provided on and after January 1, 2017 through March 31, [~~2025~~] 2027 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations; and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2017 through March 31, [~~2025~~] 2027, such trend factors attributable to the 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024 [~~and~~], 2025, 2026 and 2027 calendar years shall be established at no greater than zero percent.

§ 19. Subdivision 2 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 33 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, 2015 and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021, and on and after April 1, 2021 through March 31, 2023, and on and after April 1, 2023 through March 31, [~~2025~~] 2027;

§ 20. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 34 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential

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

§ 21. Section 3 of part MM of chapter 57 of the laws of 2021, amending the public health law relating to aiding in the transition to adulthood for children with medical fragility living in pediatric nursing homes and other settings, as amended by section 35 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

§ 3. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided however, that section one of this act shall expire and be deemed repealed [~~four~~] **six** years after such effective date; and provided further, that section two of this act shall expire and be deemed repealed [~~five~~] **seven** years after such effective date.

§ 22. Section 2 of chapter 633 of the laws of 2006, amending the public health law relating to the home based primary care for the elderly demonstration project, as amended by section 1 of item OOO of subpart B of part XXX of chapter 58 of the laws of 2020, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed January 1, [~~2026~~] **2031**.

§ 23. Section 4 of chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, as amended by section 14 of part B of chapter 57 of the laws of 2023, is amended to read as follows:

§ 4. This act shall take effect 120 days after it shall have become a law and shall expire and be deemed repealed March 31, [~~2025~~] 2027.

§ 24. 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, as amended by section 3 of part J of chapter 57 of the laws of 2024, are amended to read as follows:

(b) section four of this act shall expire and be deemed repealed December 31, [~~2025~~] 2030; 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, [~~2025~~] 2030;

(c) section six of this act shall take effect January 1, [~~2026~~] 2031; 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

§ 25. Subdivision 10 of section 365-a of the social services law, as amended by section 1 of part QQ of chapter 57 of the laws of 2022, is amended to read as follows:

10. The department of health shall establish or procure the services of an independent assessor or assessors no later than October 1, 2022, in a manner and schedule as determined by the commissioner of health, to take over from local departments of social services, Medicaid Managed Care providers, and Medicaid managed long term care plans performance of assessments and reassessments required for determining individuals' needs for personal care services, including as provided through the consumer directed personal assistance program, and other services or programs available pursuant to the state's medical assistance program as determined by such commissioner for the purpose of improving efficiency, quality, and reliability in assessment and to determine individuals' eligibility for Medicaid managed long term care plans. Notwithstanding the provisions of section 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 the commissioner may amend and extend the terms of a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, if such contract or contract amendment is for the purpose of procuring such assessment services from an independent assessor. Contracts entered into, amended, or extended pursuant to this subdivision shall not remain in force beyond September 30, [~~2025~~] 2026.

§ 26. Section 20 of part MM of chapter 56 of the laws of 2020, directing the department of health to establish or procure the services of an independent panel of clinical professionals and to develop and implement a uniform task-based assessment tool, as amended by section 3 of part QQ of chapter 57 of the laws of 2022, is amended to read as follows:

§ 20. The department of health shall establish or procure services of an independent panel or panels of clinical professionals no later than October 1, 2022, in a manner and schedule as determined by the commissioner of health, to provide as appropriate independent physician or other applicable clinician orders for personal care services, including as provided through the consumer directed personal assistance program, available pursuant to the state's medical assistance program and to determine eligibility for the consumer directed personal assistance program. Notwithstanding the provisions of section 163 of the state finance law, or sections 142 and 143 of the economic development law, or any contrary provision of law, contracts may be entered or the commissioner of health may amend and extend the terms of a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, if such contract or contract amendment is for the purpose of establishing an independent panel or panels of clinical professionals as described in this section. Contracts entered into, amended, or extended pursuant to this section shall not remain in force beyond September 30, [~~2025~~] **2026**.

§ 27. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025 provided, however, the amendments to subdivision 3 of section 3018 of the public health law made by section eight of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART C

Intentionally Omitted

PART D

Section 1. 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 5 of part D of chapter 57 of the laws of 2024, 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 each state fiscal year from July first, two thousand ten through December thirty-first, two thousand twenty-four; and 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

until December thirty-first, two thousand twenty-four; and then from calendar year January first, two thousand twenty-five through December thirty-first, two thousand twenty-five; and for each calendar year thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-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. **Provided however, that in calendar year January first, two thousand twenty-six through December thirty-first, two thousand twenty-six; and for each calendar year thereafter, such additional payments shall not be made in any calendar year in which the Medicaid rates of payment approved and in effect for general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine, as amended, result in such hospitals being ineligible to receive Medicaid disproportionate share hospital ("DSH") payments for that calendar year.** 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:

§ 2. Clause (A) of subparagraph (ii) of paragraph (b) of subdivision 5-d of section 2807-k of the public health law, as amended by section 1 of part E of chapter 57 of the laws of 2023, is amended to read as follows:

(A) **(1)** one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals**;**

(2) for the calendar years two thousand twenty-five and thereafter, in any calendar year in which the Medicaid rates of payment approved and in effect for general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine, as amended, result in such hospitals being ineligible to receive Medicaid DSH payments for that calendar year, the total distributions to major public general hospitals shall be subject to an aggregate reduction of one hundred thirteen million four hundred thousand dollars; and

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART E

Section 1. Intentionally omitted.

§ 2. Subdivision 3 of section 364-j of the social services law is amended by adding a new paragraph (d-4) to read as follows:

(d-4) Notwithstanding paragraph (a) of this subdivision, the following medical assistance recipients shall not be eligible to participate in the managed care program authorized by this section or other care coor-

dination model established by article forty-four of the public health law: any person who is permanently placed in a residential health care facility for a consecutive period of three months or more. However, nothing in this paragraph should be construed to apply to enrollees in the Medicaid Advantage Plus Program, developed to enroll persons in managed long-term care who are nursing home certifiable and who are dually eligible pursuant to section forty-four hundred three-f of the public health law. In implementing this provision, the department shall continue to support service delivery and outcomes that result in community living for enrollees.

§ 3. Section 364-j of the social services law is amended by adding a new subdivision 40 to read as follows:

40. (a) The commissioner shall be entitled to penalize managed care providers for failure to meet the contractual obligations and performance standards of the executed contract between the state and a managed care provider in place at the time of the failure.

(b) The commissioner shall have sole discretion in determining whether to impose a penalty for noncompliance with any provision of such contract.

(c) (i) Penalties imposed by this subdivision against a managed care provider shall be from two hundred fifty dollars up to twenty-five thousand dollars per violation depending on the severity of the noncompliance as determined by the commissioner.

(i-a) Any penalties assessed as a result of the review required by this subdivision shall be due and payable sixty calendar days from the issuance of a statement of penalties regardless of any dispute in the amount or interpretation of the amount contained within the statement of penalties.

(ii) The commissioner may elect, in their sole discretion, to assess penalties imposed by this section from, and as a set off against, payments due to the managed care provider, or payments that become due any time after the assessment of penalties. Deductions may continue until the full amount of the noticed penalties are paid in full.

(iii) All penalties imposed by the commissioner pursuant to this subdivision shall be paid out of the administrative costs and profits of the managed care provider. The managed care provider shall not pass the penalties imposed by the commissioner pursuant to this subdivision through to any medical services provider and/or subcontractor.

(d) For the purposes of this subdivision a violation shall mean a determination by the commissioner that the managed care organization failed to act as required under the model contract or applicable federal and state statutes, rules or regulations governing managed care organizations. For the purposes of this subdivision, a violation shall also mean each instance for which a determination has been made by the commissioner that a managed care organization failed to furnish necessary and/or required medical services or items to each enrollee. Each day that an ongoing violation continues shall be a separate violation.

(e) (i) A managed care organization may dispute the imposition of penalties in writing, and in the form and manner prescribed by the commissioner, within thirty calendar days from the date of the statement of penalties.

(ii) Disputes that are not delivered in the format and timeframe specified by the department shall be denied by the department and deemed waived by the managed care organization.

(iii) A managed care organization shall waive any arguments, materials, data, and information not contained in or accompanying a timely

submitted written dispute, including for use in any subsequent legal or administrative proceeding.

(iv) No penalties shall be assessed pursuant to this subdivision without providing an opportunity for a formal hearing conducted in accordance with section twelve-a of the public health law.

(f) Nothing in this subdivision shall prohibit the imposition of damages, penalties or other relief, otherwise authorized by law, including but not limited to cases of fraud, waste or abuse.

(g) The commissioner may promulgate any regulations necessary to implement the provisions of this subdivision.

§ 4. This act shall take effect immediately; provided, however, that section one of this act shall apply to disputes filed with the superintendent of financial services pursuant to article six of the financial services law on or after such effective date; provided further, however, that section two of this act is subject to federal financial participation; and provided further, however, that the amendments to section 364-j of the social services law made by sections two and three of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART F

Section 1. Section 2807-ff of the public health law, as added by section 1 of part II of chapter 57 of the laws of 2024, is amended to read as follows:

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

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

(b) A [~~child~~] health insurance plan [~~certified~~] serving individuals enrolled pursuant to [~~section twenty-five hundred eleven~~] title 1-A of article twenty-five of this chapter;

(c) Essential plan coverage certified pursuant to [~~section three hundred sixty-nine-gg~~] title 11-D of article five of the social services law;

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

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

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

3. The department shall post on its website the MCO provider tax approval letter by the centers for Medicare and Medicaid services (the "approval letter").

4. A health plan, as defined in subdivision one of this section, shall pay the MCO provider tax for each calendar year as follows:

(a) For Medicaid member months below two hundred fifty thousand member months, a health plan shall pay one hundred twenty-six dollars per member month;

(b) For Medicaid member months greater than or equal to two hundred fifty thousand member months but less than five hundred thousand member months, a health plan shall pay eighty-eight dollars per member month;

(c) For Medicaid member months greater than or equal to five hundred thousand member months, a health plan shall pay twenty-five dollars per member month;

(d) For essential plan member months less than two hundred fifty thousand member months, a health plan shall pay thirteen dollars per member month;

(e) For essential plan member months greater than or equal to two hundred fifty thousand member months, a health plan shall pay seven dollars per member month;

(f) For non-essential plan non-Medicaid member months, consisting of the populations covered by the products described in paragraphs (b), (d), and (e) of subdivision one of this section, less than two hundred fifty thousand member months, a health plan shall pay two dollars per member month; and

(g) For non-essential plan non-Medicaid member months greater than or equal to two hundred fifty thousand member months, a health plan shall pay one dollar and fifty cents per member month.

5. A health plan shall remit the MCO provider tax due pursuant to this section to the commissioner or their designee quarterly or at a frequency defined by the commissioner.

6. Funds accumulated from the MCO provider tax, including interest and penalties, shall be deposited and credited by the commissioner, or the commissioner's designee, to the healthcare stability fund established in section ninety-nine-ss of the state finance law.

7. (a) Every health plan subject to the approved MCO provider tax shall submit reports in a form prescribed by the commissioner to accurately disclose information required to implement this section.

(b) If a health plan fails to file reports required pursuant to this subdivision within sixty days of the date such reports are due and after notification of such reporting delinquency, the commissioner may assess a civil penalty of up to ten thousand dollars for each failure; provided, however, that such civil penalty shall not be imposed if the health plan demonstrates good cause for the failure to timely file such reports.

8. (a) If a payment made pursuant to this section is not timely, interest shall be payable in the same rate and manner as defined in subdivision eight of section twenty-eight hundred seven-j of this article.

(b) The commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their sole discretion, that the health plan has demonstrated that imposition of the full amount of the MCO provider tax pursuant to the timelines applicable under the approval letter has a high likelihood of creating an undue financial hardship for the health plan or creates a significant financial difficulty in providing needed services to Medicaid beneficiaries. In addition, the commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their

sole discretion, that the health plan did not have the information necessary from the department to pay the tax required in this section. Waiver of some or all of the interest or penalties pursuant to this subdivision shall be conditioned on the health plan's agreement to make MCO provider tax payments on an alternative schedule developed by the department that takes into account the financial situation of the health plan and the potential impact on the delivery of services to Medicaid beneficiaries.

(c) Overpayment by or on behalf of a health plan of a payment shall be applied to any other payment due from the health plan pursuant to this section, or, if no payment is due, at the election of the health plan, shall be applied to future payments or refunded to the health plan. Interest shall be paid on overpayments from the date of overpayment to the date of crediting or refunding at the rate determined in accordance with this subdivision only if the overpayment was made at the direction of the commissioner. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

9. Payments and reports submitted or required to be submitted to the commissioner pursuant to this section by a health plan shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments and reports are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made by a health plan; provided, however, that nothing in this section shall be construed as precluding the commissioner from pursuing collection of any such payments which are identified as delinquent within such six-year period, or which are identified as delinquent as a result of an audit commenced within such six-year period, or from conducting an audit of any adjustment or reconciliation made by a health plan, or from conducting an audit of payments made prior to such six-year period which are found to be commingled with payments which are otherwise subject to timely audit pursuant to this section.

10. In the event of a merger, acquisition, establishment, or any other similar transaction that results in the transfer of health plan responsibility for all enrollees under this section from a health plan to another health plan or similar entity, and that occurs at any time during which this section is effective, the resultant health plan or similar entity shall be responsible for paying the full tax amount as provided in this section that would have been the responsibility of the health plan to which that full tax amount was assessed upon the effective date of any such transaction. If a merger, acquisition, establishment, or any other similar transaction results in the transfer of health plan responsibility for only some of a health plan's enrollees under this section but not all enrollees, the full tax amount as provided in this section shall remain the responsibility of that health plan to which that full tax amount was assessed.

§ 2. Section 99-rr of the state finance law, as added by section 2 of part II of chapter 57 of the laws of 2024, is renumbered section 99-ss and is amended to read to as follows:

§ 99-ss. Healthcare stability fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special fund to be known as the "healthcare stability fund" ("fund").

2. (a) The fund shall consist of monies received from the imposition of the centers for medicare and medicaid services-approved MCO provider tax established pursuant to section twenty-eight hundred seven-ff of the

public health law, and all other monies appropriated, credited, or transferred thereto from any other fund or source pursuant to law.

(b) The pool administrator under contract with the commissioner of health pursuant to section twenty-eight hundred seven-y of the public health law shall collect moneys required to be collected as a result of the implementation of the MCO provider tax.

3. Notwithstanding any provision of law to the contrary and subject to available legislative appropriation and approval of the director of the budget, monies of the fund may be available [~~for~~] **to the department of health for the purpose of**:

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

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

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

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

4. The monies shall be paid out of the fund on the audit and warrant of the comptroller on vouchers certified or approved by the commissioner of health, or by an officer or employee of the department of health designated by the commissioner.

[~~4.~~] **5.** Monies disbursed from the fund shall be exempt from the calculation of department of health state funds medicaid expenditures under subdivision one of section ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven, as amended.

[~~5.~~] **6.** Monies in such fund shall be kept separate from and shall not be commingled with any other monies in the custody of the comptroller or the commissioner of taxation and finance. Any monies of the fund not required for immediate use may, at the discretion of the comptroller, in consultation with the director of the budget, be invested by the comptroller in obligations of the United States or the state. Any income earned by the investment of such monies shall be added to and become a part of and shall be used for the purposes of such fund.

[~~6.~~] **7.** The director of the budget shall provide quarterly reports to the speaker of the assembly, the temporary president of the senate, the chair of the senate finance committee and the chair of the assembly ways and means committee, on the receipts and distributions of the healthcare stability fund, including an itemization of such receipts and disbursements, the historical and projected expenditures, and the projected fund balance.

8. The comptroller shall provide the pool administrator with any information needed, in a form or format prescribed by the pool administrator, to meet reporting requirements as set forth in section twenty-eight hundred seven-y of the public health law or as otherwise provided by law.

§ 3. Section 1-a of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-

for-service Medicaid rates, as amended by section 1 of part NN of chapter 57 of the laws of 2024, is amended to read as follows:

§ 1-a. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of hospital inpatient services shall be subject to a uniform rate increase of seven and one-half percent in addition to the increase contained in section one of this act, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of hospital outpatient services shall be subject to a uniform rate increase of six and one-half percent in addition to the increase contained in section one of this act, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the period April 1, 2024 through March 31, 2025 Medicaid payments made for hospital services shall be increased by an aggregate amount of up to $525,000,000 in addition to the increase contained in sections one and one-b of this act subject to the approval of the commissioner of health and the director of the budget. **Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2025, and thereafter, Medicaid payments made for the operating component of hospital outpatient services shall be subject to a uniform rate increase pursuant to a plan approved by the director of the budget in addition to the applicable increase contained in section one of this act and this section, subject to the approval of the commissioner of health and the director of the budget. Notwithstanding any provision of law to the contrary, for the period April 1, 2025, and thereafter, Medicaid payments made for hospital services shall be increased by an aggregate amount of up to $725,000,000 in addition to the increase contained in section one of this act and this section, subject to the approval of the commissioner of health and the director of the budget.** Such rate increases shall be subject to federal financial participation **and the provisions established under section one-f of this act**.

§ 4. Section 1-b of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, as amended by section 2 of part NN of chapter 57 of the laws of 2024, is amended to read as follows:

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

this act subject to the approval of the commissioner of health and the director of the budget. Such rate increases shall be subject to federal financial participation. **Notwithstanding any provision of law to the contrary, for state fiscal years beginning April 1, 2025, and thereafter Medicaid payments made for nursing home services shall be increased by an aggregate amount of up to $500,000,000 in addition to the increase contained in section one of this act and this section, subject to the approval of the commissioner of health and the director of the budget. Such rate increases shall be subject to federal financial participation and the provisions established under section one-f of this act.**

(2) Notwithstanding any provision of law to the contrary, for state fiscal years beginning April 1, 2025, and thereafter, pursuant to the increases in this section and section one of this act, Medicaid payments made for the operating component of residential health care facilities services shall be subject to a uniform rate increase at a percentage which provides an aggregate amount of up to one hundred million dollars, subject to the approval of the commissioner of the department of health and the director of the division of the budget. Such rate increases shall be subject to federal financial participation; provided however that the state share of such increases may be paid regardless of approval by the Centers for Medicare and Medicaid Services.

§ 5. Sections 1-c and 1-d of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, are renumbered sections 1-d and 1-e and a new section 1-c is added to read as follows:

§ 1-c. Notwithstanding any provision of law to the contrary, for the period April 1, 2025, and thereafter, Medicaid payments made for clinic service provided by federally qualified health centers and diagnostic and treatment centers shall be increased by an aggregate amount of up to $100,000,000 in addition to any applicable increase contained in section one of this act subject to the approval of the commissioner of health and the director of the budget. Such rate increases shall be subject to federal financial participation and the provisions established under section one-f of this act.

§ 6. Section 1-d of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, as amended by section 3 of part NN of chapter 57 of the laws of 2024, and as renumbered by section five of this act, is amended to read as follows:

§ 1-d. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning April 1, 2023, and thereafter, Medicaid payments made for the operating component of assisted living programs as defined by paragraph (a) of subdivision one of section 461-l of the social services law shall be subject to a uniform rate increase of 6.5 percent in addition to the increase contained in section one of this part, subject to the approval of the commissioner of the department of health and the director of division of the budget. Notwithstanding any provision of law to the contrary, for the period April 1, 2024 through March 31, 2025, Medicaid payments for assisted living programs shall be increased by up to $15,000,000 in addition to the increase contained in this section subject to the approval of the commissioner of health and the director of the budget. **Notwithstanding any provision of law to the contrary, for the state fiscal years beginning on April 1, 2025 and thereafter, Medicaid payments for assisted living programs shall be increased by up to $30,000,000 in addition to the increase contained in this section subject to the approval of the commissioner of health and**

the director of the budget. Such rate increases shall be subject to federal financial participation and the provisions established under section one-f of this act.

§ 7. Section 1-e of part I of chapter 57 of the laws of 2022 providing a one percent across the board payment increase to all qualifying fee-for-service Medicaid rates, as added by section 4 of part NN of chapter 57 of the laws of 2024, and as renumbered by section five of this act, is amended and six new sections 1-f, 1-g, 1-h, 1-i, 1-j, and 1-k are added to read as follows:

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

§ 1-f. Such increases as added by the chapter of the laws of 2025 that added this section shall be contingent upon the availability of funds within the healthcare stability fund established by section 99-ss of the state finance law. Upon a determination by the director of the budget that the balance of such fund is projected to be insufficient to support the continuation of such increases, the commissioner of health, subject to the approval of the director of the budget, shall take steps necessary to suspend or terminate such increases, until a determination is made that there are sufficient balances to support these increases.

§ 1-g. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning on April 1, 2025 and thereafter, Medicaid payments for physicians shall be increased by up to $100,000,000 subject to the approval of the commissioner of health and the director of the budget.

§ 1-h. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning on April 1, 2025 and thereafter, Medicaid payments for early intervention providers shall be increased by up to $90,000,000 subject to the approval of the commissioner of health and the director of the budget.

§ 1-i. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning on April 1, 2025 and thereafter, Medicaid payments for certified home health agencies shall be increased by up to $30,000,000 subject to the approval of the commissioner of health and the director of the budget.

§ 1-j. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning on April 1, 2025 and thereafter, Medicaid payments for emergency medical service providers shall be increased by up to $20,000,000 subject to the approval of the commissioner of health and the director of the budget.

§ 1-k. Notwithstanding any provision of law to the contrary, for the state fiscal years beginning on April 1, 2025 and thereafter, Medicaid payments for dental providers shall be increased by up to $20,000,000 subject to the approval of the commissioner of health and the director of the budget.

§ 7-a. 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 under federal law, and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility; provided, however, that no facility shall be subject to an operating cost component lower than what was applied prior to September thirtieth, two thousand twenty-five.**

§ 7-b. 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 as required by department regulations, 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 costs; 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, and then again every three years thereafter, the department shall develop and issue updated rates of payments reflecting the actual costs and updated aggregated data consistent with the methodology described in this paragraph; provided, however, that no facility shall be subject to a rate that is less than the rate used prior to September thirtieth, two thousand twenty-five.

§ 7-c. Subparagraph (iv) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 2 of part E of chapter 57 of the laws of 2024, is amended to read as follows:

(iv) The capital cost component of rates on and after January first, two thousand nine shall: (A) fully reflect the cost of local property taxes and payments made in lieu of local property taxes, as reported in each facility's cost report submitted for the year two years prior to the rate year; (B) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by five percent; and (C) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty-four **and ending on March thirty-first, two thousand twenty-five,** for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their

mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by an additional ten percent, provided, however, that such reduction shall not apply to rates of payment for patients in pediatric residential health care facilities as defined in paragraph (c) of subdivision two of section twenty-eight hundred eight-e of this article.

§ 7-d. Paragraph (c) of subdivision 8 of section 2807-c of the public health law, as amended by section 1 of part D of chapter 57 of the laws of 2024, is amended to read as follows:

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

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

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

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

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

For any rate year, all reconciliation add-on amounts calculated on and after October first, two thousand twenty-four shall be reduced by [~~twenty~~] ten percent, and all reconciliation recoupment amounts calculated on or after October first, two thousand twenty-four shall increase by [~~twenty~~] ten percent.

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

§ 8. This act shall take effect immediately; provided, however, that sections three, four, five, six, seven, seven-a, seven-b, seven-c, and seven-d of this act shall be deemed to have been in full force and effect on and after April 1, 2025; and provided further, however, that modifications made to rates, or reconciliation add-on amounts or recoupments as outlined in sections four, five, six, seven, seven-a, seven-b, seven-c, and seven-d of this act shall be applied on a prospective basis.

PART G

Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part K of chapter 57 of the laws of 2024, 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, between July 1, 2023 and June 30, 2024, [~~and~~] between July 1, 2024 and June 30, 2025**, and between July 1, 2025 and June 30, 2026** 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, between July 1, 2023 and June 30, 2024, [~~and~~] between July 1, 2024 and June 30, 2025**, and between July 1, 2025 and June 30, 2026** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six

million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

§ 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part K of chapter 57 of the laws of 2024, 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, between July 1, 2023 and June 30, 2024, [~~and~~] between July 1, 2024 and June 30, 2025**, and between July 1, 2025 and June 30, 2026** 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, between July 1, 2023 and June 30, 2024, [~~and~~] between July 1, 2024 and June 30, 2025**, and between July 1, 2025 and June 30, 2026** 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, to the period July 1, 2023 to June 30, 2024, [~~and~~] to the period July 1, 2024 to June 30, 2025**, and to the period July 1, 2025 to June 30, 2026**.

§ 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part K of chapter 57 of the laws of 2024, 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, during the period July 1, 2023 to June 30, 2024, [~~and~~] during the period July 1, 2024 to June 30, 2025**, and during the period July 1, 2025 to June 30 2026** 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**, or covering the period July 1, 2025 to June 30, 2026** 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**, or covering the period July 1, 2025 to June 30, 2026** 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**, or covering the period July 1, 2025 to June 30, 2026** 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**, and to the period July 1, 2025 to June 30, 2026** 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**, and covering the period July 1, 2025 to June 30, 2026** a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

§ 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 4 of part K of chapter 57 of the laws of 2024, 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, [~~2025~~] 2026; 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, [~~2025~~] 2026, 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, [~~2025~~] 2026 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by

the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part K of chapter 57 of the laws of 2024, 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, June 15, 2024, [~~and~~] June 15, 2025**, and June 15, 2026** 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**, or July 1, 2025 to June 30, 2026** 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**, or July 1, 2025 to June 30, 2026** 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, June 15, 2024, [~~and~~] June 15, 2025**, and June 15, 2026** as applicable.

§ 6. Section 20 of part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions thereto, as amended by section 6 of part K of chapter 57 of the laws of 2024, 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-four~~] **twenty-five**, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [~~twenty-four~~] **twenty-five**; 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-four~~] **twenty-five** exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [~~twenty-four~~] **twenty-five**, 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-four~~] **twenty-five**, 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-four~~] **twenty-five** 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-four~~] **twenty-five**.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART H

Intentionally Omitted

PART I

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

1. The department is hereby authorized and directed to design, implement and maintain an electronic death registration system for collecting, storing, recording, transmitting, amending, correcting and authenticating information, as necessary and appropriate to complete a death registration, and to generate such documents as determined by the department in relation to a death occurring in this state. As part of the design and implementation of the system established by this section, the department shall consult with all persons authorized to use such system to the extent practicable and feasible. [~~The payment referenced in subdivision five of this section shall be collected for each burial or removal permit issued on or after the effective date of this section from the licensed funeral director or undertaker to whom such permit is issued, in the manner specified by the department and shall be used solely for the purpose set forth in subdivision five of this section.~~] Except as specifically provided in this section, the existing general duties of, and remuneration received by, local registrars in accepting and filing certificates of death and issuing burial and removal permits pursuant to any statute or regulation shall be maintained, and not altered or abridged in any way by this section.

§ 2. Subdivision 5 of section 4148 of the public health law is REPEALED.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART J

Section 1. The opening paragraph of subdivision 3 of section 2825-g of the public health law, as added by section 1 of part K of chapter 57 of the laws of 2022, is amended to read as follows:

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

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART K

Section 1. Subdivisions 1, 2, 3, 4, 5 and 6 of section 2806-a of the public health law, as added by section 50 of part E of chapter 56 of the laws of 2013, paragraph (g) of subdivision 1 as added by section 7, paragraph (a) of subdivision 2 as amended by section 8, and subparagraph

(iii) of paragraph (c) of subdivision 5 as amended by section 9 of part K of chapter 57 of the laws of 2015, are amended to read as follows:

1. For the purposes of this section:

(a) "adult care facility" shall mean an adult home or enriched housing program licensed pursuant to article seven of the social services law or an assisted living residence licensed pursuant to article forty-six-B of this chapter;

(b) "established operator" shall mean the operator of [~~an adult care facility, a general hospital or a diagnostic and treatment center that has been established and issued an operating certificate as such pursuant to this article~~] a facility, including corporations established pursuant to article ten-C of the public authorities law;

(c) "facility" shall mean (i) a general hospital or a diagnostic and treatment center that has been issued an operating certificate as such pursuant to this article; or (ii) an adult care facility;

(d) "temporary operator" shall mean any person or entity that:

(i) agrees to operate a facility on a temporary basis in the best interests of its residents or patients and the community served by the facility; and

(ii) has demonstrated that [~~he or she has~~] they have the character, competence and financial ability to operate the facility in compliance with applicable standards;

(e) "serious financial instability" shall include but not be limited to defaulting or violating key covenants of loans, or missed mortgage payments, or general untimely payment of obligations, including but not limited to employee benefit fund, payroll or payroll tax, and insurance premium obligations, or failure to maintain required debt service coverage ratios or, as applicable, factors that have triggered a written event of default notice to the department by the dormitory authority of the state of New York; and

(f) "extraordinary financial assistance" shall mean state funds provided to a facility upon such facility's request for the purpose of assisting the facility to address serious financial instability. Such funds may be derived from existing programs within the department, special appropriations, or other funds.

(g) "improper delegation of management authority by the governing authority or operator" of a general hospital shall include, but not be limited to, the delegation to an entity that has not been established as an operator of the general hospital of (i) authority to hire or fire the administrator or other key management employees; (ii) maintenance and control of the books and records; (iii) authority over the disposition of assets and the incurring of liabilities on behalf of the facility; and (iv) the adoption and enforcement of policies regarding the operation of the facility. The criteria set forth in this paragraph shall not be the sole determining factors, but indicators to be considered with such other factors that may be pertinent in particular instances. Professional expertise shall be exercised in the utilization of the criteria. All of the listed indicia need not be present in a given instance for there to be an improper delegation of authority.

2. (a) In the event that: (i) a facility seeks extraordinary financial assistance [~~and~~] or the commissioner finds that the facility is experiencing serious financial instability that is jeopardizing existing or continued access to essential services within the community[~~,~~]; or (ii) the commissioner finds that there are conditions within the facility that seriously endanger the life, health or safety of residents or patients[~~, the commissioner may appoint a temporary operator to assume~~

~~sole control and sole responsibility for the operations of that facility,~~]; or (iii) the commissioner finds that there has been an improper delegation of management authority by the governing authority or operator of a general hospital[~~,~~]; the commissioner [~~shall~~] may appoint a temporary operator to assume sole control and sole responsibility for the operations of that facility. The appointment of the temporary operator shall be effectuated pursuant to this section and shall be in addition to any other remedies provided by law.

(b) The established operator of a facility may at any time request the commissioner to appoint a temporary operator. Upon receiving such a request, the commissioner may, if [~~he or she determines~~] they determine that such an action is necessary to restore or maintain the provision of quality care to the residents or patients, or alleviate the facility's financial instability, enter into an agreement with the established operator for the appointment of a temporary operator to assume sole control and sole responsibility for the operations of that facility.

3. (a) A temporary operator appointed pursuant to this section shall, prior to [~~his or her~~] their appointment as temporary operator, provide the commissioner with a work plan satisfactory to the commissioner to address the facility's deficiencies and serious financial instability and a schedule for implementation of such plan. [~~A work plan shall not be required prior to the appointment of the temporary operator pursuant to clause (ii) of paragraph (a) of subdivision two of this section if the commissioner has determined that the immediate appointment of a temporary operator is necessary because public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of any patient or resident of the facility. Where such immediate appointment has been found to be necessary, the temporary operator shall provide the commissioner with a work plan satisfactory to the commissioner as soon as practicable.~~]

(b) The temporary operator shall use [~~his or her~~] their best efforts to implement the work plan provided to the commissioner, if applicable, and to correct or eliminate any deficiencies or financial instability in the facility and to promote the quality and accessibility of health care services in the community served by the facility. Notwithstanding any other provision of law, the temporary operator's authority shall include, but not be limited to, hiring or firing of the facility administrator and other key management employees; maintenance and control of the books and records; authority over the disposition of assets and the incurring of liabilities on behalf of the facility; and the adoption and enforcement of policies regarding the operation of the facility. Such correction or elimination of deficiencies or serious financial instability shall not include major alterations of the physical structure of the facility. During the term of [~~his or her~~] their appointment, the temporary operator shall have the sole authority to direct the management of the facility in all aspects of operation and shall be afforded full access to the accounts and records of the facility. The temporary operator shall, during this period, operate the facility in such a manner as to promote safety and the quality and accessibility of health care services or residential care in the community served by the facility. The temporary operator shall have the power to let contracts therefor or incur expenses on behalf of the facility, provided that where individual items of repairs, improvements or supplies exceed ten thousand dollars, the temporary operator shall obtain price quotations from at least three reputable sources. The temporary operator shall not be required to file

any bond. No security interest in any real or personal property comprising the facility or contained within the facility, or in any fixture of the facility, shall be impaired or diminished in priority by the temporary operator. Neither the temporary operator nor the department shall engage in any activity that constitutes a confiscation of property without the payment of fair compensation.

4. The temporary operator shall be entitled to a reasonable fee, as determined by the commissioner, and necessary expenses incurred during [~~his or her~~] **their** performance as temporary operator, to be paid from the revenue of the facility. The temporary operator shall collect incoming payments from all sources and apply them to the reasonable fee and to costs incurred in the performance of [~~his or her~~] **their** functions as temporary operator in correcting deficiencies and causes of serious financial instability. The temporary operator shall be liable only in [~~his or her~~] **their** capacity as temporary operator for injury to person and property by reason of conditions of the facility in a case where an established operator would have been liable; [~~he or she~~] **they** shall not have any liability in [~~his or her~~] **their** personal capacity, except for gross negligence and intentional acts.

5. (a) The initial term of the appointment of the temporary operator shall not exceed one hundred eighty days. After one hundred eighty days, if the commissioner determines that termination of the temporary operator would cause significant deterioration of the quality of, or access to, health care or residential care in the community or that reappointment is necessary to correct the conditions within the facility that seriously endanger the life, health or safety of residents or patients, or the financial instability that required the appointment of the temporary operator, the commissioner may authorize up to two additional [~~ninety-day~~] **initial or additional** terms.

(b) Upon the completion of the [~~two ninety-day~~] **initial or additional** terms referenced in paragraph (a) of this subdivision,

(i) if the established operator is the debtor in a bankruptcy proceeding, and the commissioner determines that the temporary operator requires additional terms to operate the facility during the pendency of the bankruptcy proceeding and to carry out any plan resulting from the proceeding, the commissioner may reappoint the temporary operator for additional ninety-day terms until the termination of the bankruptcy proceeding, provided that the commissioner shall provide for notice and a hearing as set forth in subdivision six of this section; or

(ii) if the established operator requests the reappointment of the temporary operator, the commissioner may reappoint the temporary operator for one additional ninety-day term, pursuant to an agreement between the established operator, the temporary operator and the department.

(c) [~~Within fourteen~~] **No sooner than sixty days and no later than thirty** days prior to the termination of each term of the appointment of the temporary operator, the temporary operator shall submit to the commissioner and to the established operator a report describing:

(i) the actions taken during the appointment to address [~~such~~] **the** deficiencies and financial instability **that led to appointment of the temporary operator**,

(ii) objectives for the continuation of the temporary operatorship if necessary and a schedule for satisfaction of such objectives,

(iii) recommended actions for the ongoing operation of the facility subsequent to the term of the temporary operator including recommendations regarding the proper management of the facility and ongoing agree-

ments with individuals or entities with proper delegation of management authority; and

(iv) [~~with respect to the first ninety-day term referenced in paragraph (a) of this subdivision,~~] a plan **and timeline** for sustainable operation to avoid closure, or **for the** transformation of the facility which may include any option permissible under this chapter or the social services law and implementing regulations thereof**; and, where applicable, a recommendation with rationale for an additional temporary operator term**. The report shall reflect best efforts to produce a full and complete accounting.

Each report pursuant to this paragraph shall be reviewed by the commissioner, who may consult with the temporary operator and the established operator and make corrections if necessary. Prior to expiration of the temporary operator's final term, a final report shall be submitted by the temporary operator and approved by the commissioner. The established operator shall implement the recommended actions according to the final report. If the established operator at any time demonstrates unwillingness to make or implement changes identified in the final report, the commissioner may extend the term of, or reinstate, the temporary operator, and/or the commissioner may move to amend or revoke the established operator's operating certificate.

(d) The term of the initial appointment and of any subsequent reappointment may be terminated prior to the expiration of the designated term, if the established operator and the commissioner agree on a plan of correction and the implementation of such plan.

6. (a) The commissioner, upon making a determination to appoint a temporary operator pursuant to paragraph (a) of subdivision two of this section shall, prior to the commencement of the appointment, cause the established operator of the facility to be notified of the determination by registered or certified mail addressed to the principal office of the established operator. Such notification shall include a detailed description of the findings underlying the determination to appoint a temporary operator, and the date and time of a required meeting with the commissioner and/or [~~his or her~~] **their** designee within ten business days of the date of such notice. At such meeting, the established operator shall have the opportunity to review and discuss all relevant findings. At such meeting [~~or within ten additional business days,~~] the commissioner and the established operator shall attempt to develop a mutually satisfactory plan of correction and schedule for implementation. In the event such plan of correction is agreed upon, the commissioner shall notify the established operator that the commissioner no longer intends to appoint a temporary operator. A meeting shall not be required prior to the appointment of the temporary operator pursuant to clause (ii) of paragraph (a) of subdivision two of this section if the commissioner has determined that the immediate appointment of a temporary operator is necessary because public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of any patient or resident of the facility. Where such immediate appointment has been found to be necessary, the commissioner shall provide the established operator with a notice as required under this paragraph on the date of the appointment of the temporary operator.

(b) Should the commissioner and the established operator be unable to establish a plan of correction pursuant to paragraph (a) of this subdivision, or should the established operator fail to respond to the commissioner's initial notification, a temporary operator shall be

appointed as soon as is practicable and shall operate pursuant to the provisions of this section.

(c) The established operator shall be afforded an opportunity for an administrative hearing on the commissioner's determination to appoint a temporary operator. Such administrative hearing shall occur prior to such appointment, except that the hearing shall not be required prior to the appointment of the temporary operator pursuant to clause (ii) of paragraph (a) of subdivision two of this section if the commissioner has determined that the immediate appointment of a temporary operator is necessary because public health or safety is in imminent danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of any patient or resident of the facility. An administrative hearing as provided for under this paragraph shall begin no later than [~~sixty~~] **thirty** days from the date [~~of the notice to the established operator~~] **the temporary operator is appointed** and shall not be extended without the consent of both parties. Any such hearing shall be strictly limited to the issue of whether the determination of the commissioner to appoint a temporary operator is supported by substantial evidence. A [~~copy of the~~] decision shall be **made and** sent to the [~~established operator~~] **parties no later than ten business days after completion of the hearing**.

(d) The commissioner shall, upon making a determination to reappoint a temporary operator for the first of an additional [~~ninety-day~~] **one hundred eighty-day** term pursuant to paragraph (a) of subdivision five of this section, cause the established operator of the facility to be notified of the determination by registered or certified mail addressed to the principal office of the established operator. If the commissioner determines that additional reappointments pursuant to subparagraph (i) of paragraph (b) of subdivision five of this section are required, the commissioner shall again cause the established operator of the facility to be notified of such determination by registered or certified mail addressed to the principal office of the established operator at the commencement of the first of every two additional terms. Upon receipt of such notification at the principal office of the established operator and before the expiration of ten days thereafter, the established operator may request an administrative hearing on the determination**,** to begin no later than [~~sixty~~] **thirty** days from the date of the reappointment of the temporary operator. Any such hearing shall be strictly limited to the issue of whether the determination of the commissioner to reappoint the temporary operator is supported by substantial evidence.

§ 2. This act shall take effect immediately; provided, however, that the amendments to section 2806-a of the public health law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART L

Intentionally Omitted

PART M

Section 1. Subdivision 4 of section 2805-a of the public health law, as renumbered by chapter 2 of the laws of 1988, is renumbered subdivision 5 and a new subdivision 4 is added to read as follows:

4. Every general hospital operating under the provisions of this article shall file with the commissioner and provide a copy to the attorney general, in a format prescribed by the department, within one hundred eighty days after the end of its fiscal year, a certified report, to be conspicuously posted on the department's website, showing how the hospital spent community benefit expenses, including specific mention of any community benefit expenses supporting the hospital's local community, as well as, but not limited to:

(a) Financial assistance at cost, which shall include any free or discounted services for those who cannot afford to pay and meet the hospital's financial assistance criteria;

(b) Unreimbursed costs from Medicaid;

(c) Unreimbursed costs from the children's health insurance program or other means-tested government programs;

(d) Community health improvement services and community benefit operations, which shall include costs associated with planning or operating community benefit programs, but shall not include activities or programs if they are provided primarily for marketing purposes or if they are more beneficial to the hospital than to the community;

(e) Health professions education programs that result in a degree or certificate or training necessary for residents or interns to be certified;

(f) Subsidized health services, which shall include services with a negative margin, services that meet an identifiable community need and services that if no longer offered would be unavailable or fall to the responsibility of another nonprofit or government agency;

(g) Research that produces generalizable knowledge and is funded by tax-exempt sources;

(h) Cash and in-kind contributions for community benefit, for which in-kind donations may include the indirect cost of space donated to community groups and the direct cost of donated food or supplies; and

(i) How such community benefit expenses support the priorities of New York state, as outlined in guidance, including but not limited to the New York state prevention agenda as developed by the department.

§ 2. This act shall take effect October 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 N

Section 1. Subdivision 1 of section 250 of the public health law, as added by chapter 338 of the laws of 1998, is amended to read as follows:

1. A spinal cord injury research board is hereby created within the department for the purpose of administering spinal cord injury research projects and administering the spinal cord injury research trust fund created pursuant to section ninety-nine-f of the state finance law. The purpose of research projects administered by the board shall be [~~neurological~~] research towards treatment and a cure for such injuries and their effects including, but not limited to, health-related quality of life improvements and cases where there is spinal cord injury as a result of a traffic or vehicle accident. The members of the spinal cord injury research board shall include but not be limited to representatives of the following fields: neuroscience, neurology, neuro-surgery, neuro-pharmacology, and spinal cord rehabilitative medicine. The board shall be composed of thirteen members, seven of whom shall be appointed

by the governor, two of whom shall be appointed by the temporary president of the senate, two of whom shall be appointed by the speaker of the assembly, one of whom shall be appointed by the minority leader of the senate, and one of whom shall be appointed by the minority leader of the assembly.

§ 2. Subdivision 2 of section 251 of the public health law, as added by chapter 338 of the laws of 1998, is amended to read as follows:

2. Solicit, receive, and review applications from public and private agencies and organizations and qualified research institutions for grants from the spinal cord injury research trust fund, created pursuant to section ninety-nine-f of the state finance law, to conduct research programs which focus on the treatment and cure of spinal cord [~~injury~~] **injuries and their effects**. The board shall make recommendations to the commissioner, and the commissioner shall, in [~~his or her~~] **their** discretion, grant approval of applications for grants from those applications recommended by the board.

§ 2-a. Subdivision 2 of section 99-f of the state finance law, as amended by chapter 565 of the laws of 2024, is amended to read as follows:

2. The fund shall consist of all monies appropriated for its purpose, all monies required by this section or any other provision of law to be paid into or credited to such fund, and monies of at least [~~eight~~] **twenty** million [~~five hundred thousand~~] dollars collected by the mandatory surcharges imposed pursuant to subdivision one of section eighteen hundred nine of the vehicle and traffic law. Nothing contained herein shall prevent the department of health 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. This act shall take effect immediately.

PART O

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 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. Subdivision 2 of section 3342 of the public health law, as amended by chapter 466 of the laws of 2024, is amended and a new subdivision 2-a is added 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~~].

2-a. A practitioner in any institutional dispenser may dispense controlled substances as emergency treatment to a patient for use off the premises of the institutional dispenser as authorized by the federal drug enforcement administration for the purpose of initiating maintenance treatment, detoxification treatment, or both.

§ 20-a. Paragraph a of subdivision 1 of section 35 of the judiciary law, as amended by chapter 479 of the laws of 2022, is amended to read as follows:

a. When a court orders a hearing in a proceeding upon a writ of habeas corpus to inquire into the cause of detention of a person in custody in a state institution, or when it orders a hearing in a civil proceeding to commit or transfer a person to or retain [~~him~~] **a person** in a state institution when such person is alleged to be mentally ill, mentally defective or a [~~narcotic addict~~] **person with substance use disorder**, or when it orders a hearing for the commitment of the guardianship and custody of a child to an authorized agency by reason of the mental illness or developmental disability of a parent, or when it orders a hearing to determine whether consent to the adoption of a child shall be required of a parent who is alleged to be mentally ill or developmentally disabled, or when it orders a hearing to determine the best interests of a child when the parent of the child revokes a consent to the adoption of such child and such revocation is opposed or in any adoption or custody proceeding if it determines that assignment of counsel in such cases is mandated by the constitution of this state or of the United States, the court may assign counsel to represent such person if it is satisfied that [~~he~~] **such person** is financially unable to obtain counsel. Upon an appeal taken from an order entered in any such proceeding, the appellate court may assign counsel to represent such person upon the appeal if it is satisfied that [~~he~~] **such person** is financially unable to obtain counsel.

§ 20-b. Subdivision 4 of section 35 of the judiciary law, as amended by section 3 of part GG of chapter 56 of the laws of 2023, is amended to read as follows:

4. In any proceeding described in paragraph a of subdivision one of this section, when a person is alleged to be mentally ill, mentally defective or a [~~narcotic addict~~] **person with substance use disorder**, the court which ordered the hearing may appoint no more than two psychiatrists, certified psychologists or physicians to examine and testify at the hearing upon the condition of such person. A psychiatrist, psychologist or physician so appointed shall, upon completion of their services, receive reimbursement for expenses reasonably incurred and reasonable compensation for such services, to be fixed by the court. Such compensation shall not exceed three thousand dollars, except that in extraordinary circumstances the court may provide for compensation in excess of the foregoing limits.

§ 20-c. Paragraph (i) of subdivision (b) of section 32.05 of the mental hygiene law, as amended by section 3 of part Z of chapter 57 of the laws of 2019, is amended to read as follows:

(i) Methadone, or such other controlled substance designated by the commissioner of health as appropriate for such use, may be administered to [~~an addict~~] a person with substance use disorder, as defined in section thirty-three hundred two of the public health law, by individual physicians, groups of physicians and public or private medical facilities certified pursuant to article twenty-eight or thirty-three of the public health law as part of a chemical dependence program which has been issued an operating certificate by the commissioner pursuant to subdivision (b) of section 32.09 of this article, provided, however, that such administration must be done in accordance with all applicable federal and state laws and regulations. Individual physicians or groups of physicians who have obtained authorization from the federal government to administer buprenorphine to [~~addicts~~] people with substance use disorder may do so without obtaining an operating certificate from the commissioner.

§ 20-d. Paragraph 5 of subdivision (b) of section 32.09 of the mental hygiene law, as added by chapter 558 of the laws of 1999, is amended to read as follows:

5. the applicant will establish procedures to effectively implement a detoxification program to further relieve [~~addicts~~] people with substance use disorder from dependence upon methadone or such other controlled substances prescribed for treatment in subject maintenance programs.

§ 21. 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 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.

§ 22. 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 substance use disorder or habitual user.

§ 23. The title heading of title V 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 SUBSTANCE USE DISORDER AND HABITUAL USERS

§ 24. 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 substance use disorder or habitual users of controlled substances, except as provided by this title or title III of this article.

§ 25. 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 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; **or**

(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, administer 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 substance use disorder** or habitual user by a practitioner and administered by a practitioner [~~or~~]**,** registered nurse**, or emergency medical technician-paramedic, acting within their scope of practice,** 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~~] **by a person with substance use disorder** by a practitioner and dispensed or administered by a practitioner or [~~his~~] **their** designated agent as interim treatment for [~~an addict~~] **a person with substance use disorder** on a waiting list for admission to an authorized maintenance program **or while arrangements are being made for referral to treatment for such substance use disorder**.

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 substance use disorder** by a practitioner or by [~~his~~] **their** 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 substance use disorder** by a practitioner or by [~~his~~] **their** designated agent acting under the direction and supervision of a practitioner, as part of a substance [~~abuse~~] **use** or chemical dependence program approved pursuant to article [~~twenty-three or~~] thirty-two of the mental hygiene law.

§ 26. Section 3372 of the public health law, as amended by chapter 195 of the laws of 1973, is amended to read as follows:

§ 3372. Practitioner patient reporting. It shall be the duty of every attending practitioner and every consulting practitioner to report promptly to the commissioner, or [~~his~~] **the commissioner's** duly designated agent, the name and, if possible, the address of, and such other data as may be required by the commissioner with respect to, any person under treatment if [~~he~~] **the practitioner** finds that such person is [~~an addict~~] **a person with substance use disorder** or a habitual user [~~of any narcotic drug~~]. Such report shall be kept confidential and may be utilized only for statistical, epidemiological or research purposes, except that those reports which originate in the course of a criminal proceeding other than under section 81.25 of the mental hygiene law shall be subject only to the confidentiality requirements of section thirty-three hundred seventy-one of this article.

§ 26-a. Subdivisions 2 and 3 of section 396-h of the county law, as added by chapter 818 of the laws of 1971, are amended to read as follows:

2. To establish in-patient and out-patient treatment facilities for persons [~~addicted to the use of drugs and drug abusers~~] **with substance use disorders**. Such facilities shall include, but shall not be limited to:

a. detoxification centers and clinics for the out-patient treatment of [~~drug abusers and addicts~~] **persons with substance use disorders**;

b. a treatment center where [~~drug abusers and addicts~~] **persons with substance use disorders** may obtain professional counseling from physicians, psychologists, psychiatrists and where possible, [~~former drug abusers and addicts~~] **other persons with substance use disorders**;

c. half-way houses to provide continuing treatment for [~~drug abusers and addicts~~] **persons with substance use disorders**.

3. To create a referral program whereby [~~drug abusers, addicts~~] **persons with substance use disorders** and persons and agencies concerned with their treatment will make use of the aforementioned treatment facilities;

§ 26-b. Subdivisions 2 and 3 of section 121 of the general city law, as added by chapter 820 of the laws of 1971, are amended to read as follows:

2. To establish in-patient and out-patient treatment facilities for persons [~~addicted to the use of drugs and drug abusers~~] **with substance use disorders**. Such facilities shall include, but shall not be limited to:

a. detoxification centers and clinics for the out-patient treatment of [~~drug abusers and addicts~~] **persons with substance use disorders**;

b. a treatment center where [~~addicts~~] **persons with substance use disorders** may obtain professional counseling from physicians, psychologists, psychiatrists and where possible, [~~former drug abusers and addicts~~] **other persons with substance use disorders**;

c. half-way houses to provide continuing treatment for [~~drug abusers and addicts~~] **persons with substance use disorders**.

3. To create a referral program whereby [~~drug abusers, addicts~~] **persons with substance use disorders** and persons and agencies concerned with their treatment will make use of the aforementioned treatment facilities;

§ 27. This act shall take effect immediately.

PART P

Section 1. Legislative findings. The legislature finds that for nearly 40 years, the federal Emergency Medical Treatment and Labor Act (EMTALA) has required emergency rooms to provide stabilizing treatment to patients in emergency situations. Moreover, for decades the federal government has consistently recognized that EMTALA requires hospitals to provide emergency care, including abortion care, for pregnant patients in need.

However, the legislature finds that in the wake of the overturning of Roe v. Wade, states hostile to reproductive freedom have banned or severely restricted abortion care and asserted that EMTALA protections do not apply to emergent pregnancy complications, leading to hospitals delaying or denying care, forcing pregnant people to experience life and health-altering complications. The judiciary's support for such interpretations of EMTALA has made it clear that New York State can no longer rely on federal protections, and it is incumbent on the state to encode the obligation of all hospitals to provide stabilizing care, including

abortion, to all individuals in need in order to safeguard the health of pregnant New Yorkers.

§ 2. Section 2805-b of the public health law, as amended by chapter 787 of the laws of 1983, subdivision 1 as amended by chapter 121 of the laws of 1987, subdivision 3 as amended by chapter 723 of the laws of 1989, and subdivision 5 as amended by section 77 of part PP of chapter 56 of the laws of 2022, is amended to read as follows:

§ 2805-b. Admission of patients and emergency treatment of nonadmitted patients. 1. For purposes of this section, the following terms shall have the following meanings:

(a)(i) "Emergency medical condition" shall mean:

(1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(A) serious injury or illness;

(B) placing the health of the individual in serious jeopardy;

(C) serious impairment to bodily functions, including risks to future fertility;

(D) serious dysfunction of any bodily organ or part; or

(2) with respect to a pregnant person who is in active labor:

(A) that there is inadequate time to effect a safe transfer to another hospital before delivery; or

(B) that transfer poses a threat to the health or safety of the pregnant person or the pregnancy.

(ii) "Emergency medical condition" includes, but is not limited to, ectopic pregnancy; complications of or resulting from pregnancy, pregnancy loss, or attempted termination of pregnancy; risks of infection; risks to future fertility; sepsis; acute blood loss; previable preterm premature rupture of membranes (PPROM) or cervical insufficiency; placenta abnormalities; acute mental illness; acute or emergent hypertensive disorders, such as preeclampsia, or any other condition a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice determines, in the practitioner's reasonable medical judgment, to be an emergency, as defined in this paragraph.

(b) "Stabilize" shall mean, with respect to an emergency medical condition described in clause one of subparagraph (i) of paragraph (a) of this subdivision, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in clause two of subparagraph (i) of paragraph (a) of this subdivision, to deliver, including the placenta. "Stabilizing treatment" includes abortion pursuant to section twenty-five hundred ninety-nine-bb of this article when failure to provide an abortion will, within reasonable probability, result in material deterioration of the patient's condition upon or during transfer of the patient from the facility.

(c) "Transfer" shall mean the movement (including the discharge) of an individual outside of a general hospital's facilities at the direction of any person employed by, or affiliated or associated, directly or indirectly, with, the general hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(d) "Appropriate transfer" shall mean a transfer to a medical facility:

(i) in which the transferring general hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health;

(ii) in which the receiving facility:

(1) has available space and qualified personnel for the treatment of the individual; and

(2) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) in which the transferring general hospital sends to the receiving facility all medical records related to the emergency condition for which the individual has presented available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification or copy thereof provided under paragraph (d) of subdivision three of this section, unless the patient objects;

(iv) in which the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer; and

(v) in which prior to the transfer, the emergency medical technician or paramedic assigned to accompany the patient in the ambulance shall be provided with a completed form which shall include at least the following information and such additional information as the commissioner may require:

(1) the patient's name;

(2) the diagnosed condition of the patient;

(3) any treatment administered to the patient;

(4) any medication given to the patient;

(5) the name of the health care practitioner ordering the transfer;

(6) the name of the hospital from which the patient is being transferred;

(7) the name of the health care practitioner or practitioners who is or are willing and authorized to receive the patient at the new location;

(8) the name of the hospital or other facility that is to receive the patient;

(9) the date and time of transfer; and

(10) the signature of the health care practitioner ordering the transfer. The form for this purpose shall be promulgated by the commissioner and distributed to all general hospitals. The completed form shall be given to the receiving facility upon completion of the ambulance trip for use by the receiving health care practitioner.

2. Every general hospital as defined in this article shall admit any person who is in need of immediate hospitalization with all convenient speed and shall not before admission question the patient or any member of [~~his or her~~] the patient's family concerning insurance, credit or payment of charges, provided, however, that the patient or a member of [~~his or her~~] the patient's family shall agree to supply such information promptly after the patient's admission. However, no general hospital shall require any patient or member of [~~his or her~~] the patient's family to write or to sign during those times when the religious tenets of such person temporarily prohibit [~~him or her~~] such person's from performing such acts. No general hospital shall transfer any patient to another hospital or health care facility on the grounds that the patient is unable to pay or guarantee payment for services rendered. Every general hospital which maintains facilities for providing out-patient emergency

medical care must provide such care to any person who, in the opinion of a [~~physician~~] **health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice**, requires such care.

[~~2. In cities with a population of one million or more, (a) a general hospital shall provide emergency medical care and treatment to all persons in need of such care and treatment who arrive at the entrance to such hospital therefor. Any general hospital which fails to provide such treatment shall be guilty of a misdemeanor. However, the commissioner may exempt a general hospital from the provisions of this paragraph if he determines such general hospital is structured to provide specialized or limited treatment.~~

~~(b) Any licensed medical practitioner who refuses to treat a person arriving at a general hospital to receive emergency medical treatment who is in need of such treatment; or any person who in any manner excludes, obstructs or interferes with the ingress of another person into a general hospital who appears there for the purpose of being examined or diagnosed or treated; or any person who obstructs or prevents such other person from being examined or diagnosed or treated by an attending physician thereat shall be guilty of a misdemeanor and subject to a term of imprisonment not to exceed one year and a fine not to exceed one thousand dollars. Any emergency medical technician, paramedic or ambulance driver who transports a person to a general hospital where such person is refused entrance by anyone or is refused examination, diagnosis or treatment by an attending physician thereat shall report all such incidents to the state commissioner of health or his designee, on a form which shall be promulgated by such commissioner. After examination, diagnosis and treatment by an attending physician and where, in the opinion of such physician, the patient has been stabilized sufficiently to permit it, subsequent medical care may be provided or procured by the general hospital at a location other than the general hospital if, in the opinion of the attending physician, it is in the best interest of the patient because the general hospital does not have the proper equipment or personnel at hand to deal with the particular medical emergency or because all appropriate beds are filled and none are likely to become available within a reasonable time after the patient has been stabilized.~~

~~(c) Whenever a previously stabilized emergency room patient is thereafter transferred for medical care to another location by means of an ambulance, the attending physician authorizing the transfer in the general hospital from which the patient is transferred shall determine that a receiving hospital is available and willing to receive such patient and that an attending physician thereat is available and willing to admit such patient. Just prior to the transfer, the emergency medical technician or paramedic assigned to accompany the patient in the ambulance shall be provided with a completed form which shall include at least the following information and such additional information as the commissioner may require:~~

~~(i) the patient's name;~~

~~(ii) the diagnosed condition of the patient;~~

~~(iii) any treatment administered to the patient;~~

~~(iv) any medication given to the patient;~~

~~(v) the name of the physician ordering the transfer;~~

~~(vi) the name of the hospital from which the patient is being transferred;~~

~~(vii) the name of the physician or physicians who is or are willing and authorized to receive the patient at the new location;~~
~~(viii) the name of the hospital or other facility that is to receive the patient;~~
~~(ix) the date and time of transfer; and~~
~~(x) the signature of the physician ordering the transfer.~~
~~The form for this purpose shall be promulgated by the commissioner and distributed to all general hospitals in any such city. The completed form shall be given to the receiving facility upon completion of the ambulance trip for use by the receiving physician.~~]

3. (a) Medical screening required. Every general hospital must provide appropriate medical screening examination within the capability of the general hospital's emergency department, including ancillary services routinely available to the emergency department when a request is made by an individual or on the individual's behalf for examination or treatment for a medical condition to determine whether an emergency medical condition exists. With respect to a pregnant person, such medical screening examination must include a determination by a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice as to whether the individual is in active labor. A general hospital may not delay provision of an appropriate medical screening examination or further medical examination, and treatment required under paragraph (b) of this subdivision in order to inquire about the individual's method of payment or insurance status.

(b) Necessary stabilizing treatment for emergency medical conditions and labor. If any individual comes to a general hospital and the general hospital determines that the individual has an emergency medical condition, the general hospital must provide either:

(i) within the staff and facilities available at the general hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition; or

(ii) for transfer of the individual to another medical facility in accordance with paragraph (e) of this subdivision.

(c) Obligation to provide certain treatment. Admission of an individual experiencing an emergency medical condition does not relieve a general hospital of the obligation to provide any such treatment that, within reasonable probability, will prevent material deterioration of the patient's condition.

(d) Refusal to consent to treatment. A general hospital is deemed to meet the requirements of paragraph (b) of this subdivision with respect to an individual if the general hospital offers the individual the further medical examination and treatment described in such paragraph and informs the individual, or a person legally authorized to make health care decisions on behalf of the individual, of the risks and benefits to the individual of such examination and treatment, but the individual, or a person legally authorized to make health care decisions on behalf of the individual, refuses to consent to the examination and treatment. The general hospital shall take all reasonable steps to secure the individual's written informed consent, or that of an individual legally authorized to make health care decisions on behalf of the individual, to refuse such examination and treatment.

(e) Restricting transfers until individual stabilized. (i) If an individual at a general hospital has an emergency medical condition which has not been stabilized, the general hospital may not transfer the individual unless:

(1) the individual, or a person legally authorized to make health care decisions on behalf of the individual, after being informed of the general hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility; and

(2) a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice has signed a certification that:

(A) based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual; and

(B) the transfer is an appropriate transfer to that facility;

(ii) A certification described in clauses one and two of subparagraph (i) of this paragraph shall include a summary of the risks and benefits upon which the certification is based.

(f) Acceptance of transfer. A general hospital shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the general hospital has the capacity to treat the individual.

(g) No delay in examination or treatment. A general hospital may not delay provision of an appropriate medical screening examination required under paragraph (a) of this subdivision or further medical examination and treatment required under paragraph (b) of this subdivision in order to inquire about the individual's method of payment or insurance status.

(h) Retaliation prohibited. A general hospital may not penalize, retaliate, discriminate or otherwise take an adverse action against a health care practitioner, because the practitioner refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or because the practitioner provides treatment necessary to stabilize a patient who is, in the practitioner's reasonable medical judgment, experiencing an emergency medical condition. A general hospital may not penalize, retaliate, discriminate or otherwise take an adverse action against any individual because the individual reports a violation of a requirement of this subdivision.

4. General hospitals shall adopt, implement, and periodically update standard protocols for the management of emergency medical conditions, including diagnosis, stabilization, treatment, or transfer to another medical unit or facility.

5. A general hospital within a city with a population of one million or more may request the emergency medical service of such city's health and hospitals corporation or any person, firm, organization or corporation providing ambulance service to divert ambulances to another hospital only under the following circumstances:

A request for diversion of emergency patients with life threatening conditions shall only be made by a hospital when acceptance of an additional critical patient may endanger the life of that patient or the life of another patient. A request for the diversion of other emergency patients shall only be made when all appropriate beds are filled and shall be withdrawn as soon as a bed is available. Notwithstanding the foregoing, all requests for diversion must be renewed at the beginning of each tour of duty as designated by the emergency medical service of such city's health and hospitals corporation.

Diversion of patients with certain medical conditions which, in the best interest of the patients, require their transport directly to specialty referral centers shall be permitted following the designation of such specialty referral centers. Diversion of patients with psychiat-

ric conditions to comprehensive psychiatric emergency programs, as such term is defined in section 1.03 of the mental hygiene law, and subject to the provisions of section 31.27 of such law, shall only be permitted following the designation of the programs by the commissioners of health and mental health to receive such patients.

[~~4.~~] 6. Nothing in this section shall be construed to deny to [~~the attending physician~~] a health care practitioner licensed, certified, or authorized under title eight of the education law, acting within their lawful scope of practice the right to evaluate the medical needs of persons arriving at the hospital for emergency treatment and to delay or deny medical treatment where, in the opinion of the [~~attending physician~~] health care practitioner, no [~~actual medical~~] emergency medical condition exists. [~~However, no person actually in need of emergency treatment, as determined by the attending physician, shall be denied such treatment by a general hospital in cities with a population of one million or more for any reason whatsoever.~~]

[~~5.~~] 7. The staff of a general hospital shall: (a) inquire whether or not the person admitted has served in the United States armed forces. Such information shall be listed on the admissions form; (b) notify any admittee who is a veteran of the possible availability of services at a hospital operated by the United States veterans health administration, and, upon request by the admittee, such staff shall make arrangements for the individual's transfer to a United States veterans health administration hospital, provided, however, that transfers shall be authorized only after it has been determined, according to accepted clinical and medical standards, that the patient's condition has stabilized and transfer can be accomplished safely and without complication; and (c) provide any admittee who has served in the United States armed forces with a copy of the "Information for Veterans concerning Health Care Options" fact sheet, maintained by the department of veterans' services pursuant to subdivision twenty-nine of section four of the veterans' services law prior to discharging or transferring the patient. The commissioner shall promulgate rules and regulations for notifying such admittees of possible available services and for arranging a requested transfer.

8. (a) Whenever it appears to the attorney general, either upon complaint or otherwise, that any person or persons has acts or practices stated to be unlawful under this section, the attorney general may bring an action or special proceeding in the name and on behalf of the people of the state of New York to enjoin any violation of this section and to obtain civil penalties of not more than fifty thousand dollars per violation and to obtain any such other and further relief as the court may deem proper, including preliminary relief.

(b) The remedies provided by this section shall be in addition to any other lawful remedy available.

(c) Any action or special proceeding brought by the attorney general pursuant to this section must be commenced within six years of the date on which the attorney general became aware of the violation.

(d) In connection with any proposed action or special proceeding under this section, the attorney general is authorized to take proof and make a determination of the relevant facts, and to issue subpoenas in accordance with the civil practice law and rules. The attorney general may also require such other data and information as they may deem relevant and may require written responses to questions under oath. Such power of subpoena and examination shall not abate or terminate by reason of any

action or special proceeding brought by the attorney general under this article.

(e) This section shall apply to all acts declared to be unlawful in this section, whether or not subject to any other law of this state, and shall not supersede, amend or repeal any other law of this state.

(f) The attorney general may assess civil penalties under this section only if there are no fines assessed for the violation by the federal government.

9. The commissioner shall revise and repeal conflicting regulations as may be necessary and proper to carry out effectively the provisions of this section.

§ 3. Subdivision 3 of section 2805-b of the public health law, as added by chapter 787 of the laws of 1983, is renumbered subdivision 5.

§ 4. Section 2803-o-1 of the public health law is REPEALED.

§ 5. The public health law is amended by adding a new section 2832 to read as follows:

§ 2832. Interference with care; prohibited. 1. If a health care practitioner licensed pursuant to title eight of the education law is acting in good faith, within the practitioner's scope of practice, and within the relevant standard of care, a hospital may not limit the health care practitioner's provision of medically accurate and comprehensive information and resources to a patient regarding the patient's health status including, but not limited to, diagnosis, prognosis, recommended treatment, treatment alternatives, information about available services and where and how to obtain them, and any potential risks to the patient's health or life.

2. A health care entity shall not penalize, retaliate, discriminate or otherwise take adverse action against a health care practitioner engaging in communications consistent with this section.

3. The department shall design, prepare and make available online written materials to clearly inform health care practitioners and staff of the provisions of this section.

§ 6. Conflict of laws. To the extent that any laws in the state of New York conflict with this act, this act shall govern. If any part of this section is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

§ 7. Severability. If any clause, sentence, paragraph, section or part of this act be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder hereof but shall be applied in its operation to the clause, sentence, paragraph, section or part hereof directly involved in the controversy in which such judgment shall have been rendered.

§ 8. This act shall take effect immediately; provided, however, that the amendments to subdivision 3 of section 2805-b of the public health law made by section two of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 21 of chapter 723 of the laws of 1989, as amended, when upon such date the provisions of section three of this act shall take effect.

PART Q

Section 1. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (nn) to read as follows:

(nn) (i) Medical assistance shall include the coverage of the following services for individuals with infertility, including iatrogenic infertility directly or indirectly caused by medical treatment and infertility with an underlying diagnosis:

(1) standard fertility preservation services to prevent or treat infertility, which shall include medically necessary collection, freezing, preservation and storage of oocytes or sperm, and such other standard services that are not experimental or investigational; together with prescription drugs, which shall be limited to federal food and drug administration approved medications and subject to medical assistance program coverage requirements;

(2) coverage of the costs of storage of oocytes or sperm shall be subject to continued medical assistance program eligibility of the individual with iatrogenic infertility, and shall terminate upon any discontinuance of medical assistance eligibility; and

(3) three cycles of in-vitro fertilization used in the treatment of infertility.

(ii) In the event that federal financial participation for such fertility preservation services is not available, medical assistance shall not include coverage of these services.

(iii) For purposes of this paragraph, "iatrogenic infertility" means an impairment of fertility resulting from surgery, radiation, chemotherapy, sickle cell treatment, or other medical treatment affecting reproductive organs or processes; and a "cycle" is defined as either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer.

§ 2. Section 4 of part K of chapter 82 of the laws of 2002 amending the insurance law and the public health law relating to coverage for the diagnosis and treatment of infertility, is REPEALED.

§ 3. The public health law is amended by adding a new section 2599-bb-2 to read as follows:

§ 2599-bb-2. Improved access to infertility health care services grant program. 1. The commissioner, subject to the availability of funds pursuant to section twenty-eight hundred seven-v of this chapter, shall establish a program to provide grants to health care providers for the purpose of improving access to and expanding health care services related to the range of care for infertility. Such program shall fund uncompensated health care services related to the range of care for infertility, to ensure the affordability of and access to care for individuals who lack the ability to pay for care, lack insurance coverage, are underinsured, or whose insurance is deemed unusable by the rendering provider. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, grants provided pursuant to such program may be made without competitive bid or request for proposal.

2. Services, treatments, and procedures paid for pursuant to the grant program shall be made available only in accordance with standards, protocols, and other parameters established by the commissioner, which shall incorporate but not be limited to the American Society for Reproductive Medicine (ASRM) and the American College of Obstetricians and

Gynecologists (ACOG) standards for the appropriateness of individuals, providers, treatments, and procedures.

3. At least one such provider shall be located in the city of New York and one such provider shall be located in an upstate region. Any organization or provider receiving funds from the program shall take all necessary steps to ensure the confidentiality of the individuals receiving services, treatments or procedures paid for pursuant to the grant program pursuant to state and federal laws.

§ 3-a. Under the authority of state plan amendment #17-0058, as amended by state plan amendment #23-0050, the department of health shall establish an alternative payment methodology (APM) for federally qualified health centers to preserve and improve patient access to fertility care. Such payments shall be in addition to any prospective payment system (PPS) or any other alternative payment methodology for eligible federally qualified health centers. The APM shall be determined by the department and shall equal the difference between what the eligible provider would have been paid for certain classes of fertility drugs under section 340B of the federal public health services act between January 1, 2024 and December 31, 2024 and the amount that the eligible provider would have been reimbursed for such drugs by a managed care organization, if covered by such managed care organization. For purposes of this section, eligible fertility drugs shall be limited to gondotropion, GNRH antagonists, and GNRH agonists.

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025; provided, however, that section one of this act shall take effect October 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 R

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 interoperable healthcare response, assessment, treatment, transportation, emergency medical dispatch, medical direction, research, and practitioner education that provides essential emergency and non-emergency care and transportation for the ill and injured and enhances preparedness and mitigates risks to the public.

§ 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 S

Section 1. Section 4552 of the public health law, as added by section 1 of part M of chapter 57 of the laws of 2023, is amended to read as follows:

§ 4552. Notice of material transactions; requirements. 1. A health care entity shall submit to the department written notice, with supporting documentation as described below and further defined in regulation developed by the department, which the department shall be in receipt of at least [~~thirty~~] sixty days before the closing date of the transaction, in the form and manner prescribed by the department. Immediately upon the submission to the department, the department shall submit electronic copies of such notice with supporting documentation to the antitrust, health care and charities bureaus of the office of the New York attorney general. Such written notice shall include, but not be limited to:

(a) The names of the parties to the material transaction and their current addresses;

(b) Copies of any definitive agreements governing the terms of the material transaction, including pre- and post-closing conditions;

(c) Identification of all locations where health care services are currently provided by each party and the revenue generated in the state from such locations;

(d) Any plans to reduce or eliminate services and/or participation in specific plan networks;

(e) The closing date of the proposed material transaction;

(f) A brief description of the nature and purpose of the proposed material transaction including:

(i) the anticipated impact of the material transaction on cost, quality, access, health equity, and competition in the impacted markets, which may be supported by data and a formal market impact analysis; and

(ii) any commitments by the health care entity to address anticipated impacts[~~.~~];

(g) A statement as to whether any party to the transaction, or a controlling person or parent company of such party, owns any other health care entity which, in the past three years has closed operations, is in the process of closing operations, or has experienced a substantial reduction in services provided. The parties shall specifically identify the health care entity or entities subject to such closure or substantial service reduction and detail the circumstances of such;

(h) A statement as to whether a sale-leaseback agreement or mortgage or lease payments or other payments associated with real estate are a component of the proposed transaction and if so, the parties shall provide the proposed sale-leaseback agreement or mortgage, lease, or real estate documents with the notice; and

(i) A statement as to whether any direct financial interest or materially indirect financial interest in the ownership or operation of the health care entity, aside from those interests outlined in paragraph (h) of this subdivision, are a component of the proposed transaction and if so, the parties shall provide details of the financial interest as determined necessary by the commissioner.

2. [~~(a) Except as provided in paragraph (b) of this subdivision, supporting documentation as described in subdivision one of this section shall not be subject to disclosure under article six of the public officers law.~~

~~(b)~~] During such [~~thirty-day~~] sixty-day period prior to the closing date, the department shall post on its website:

[~~(i)~~] (a) a summary of the proposed transaction;

[~~(ii)~~] (b) an explanation of the groups or individuals likely to be impacted by the transaction;

[~~(iii)~~] (c) information about services currently provided by the health care entity, commitments by the health care entity to continue such services and any services that will be reduced or eliminated; and

[~~(iv)~~] (d) details about how to submit comments, in a format that is easy to find and easy to read.

3. (a) A health care entity that is a party to a material transaction shall notify the department upon closing of the transaction in the form and manner prescribed by the department.

(b) Annually, for a five-year period following closing of the transaction and on the date of such anniversary, parties to a material transaction shall notify the department, in the form and manner prescribed by the department, of factors and metrics to assess the impacts of the transaction on cost, quality, access, health equity, and competition. The department may require that any party to a transaction, including any parents or subsidiaries thereof, submit additional documents and information in connection with the annual report required under this paragraph, to the extent such additional information is necessary to assess the impacts of the transaction on cost, quality, access, health equity, and competition or to verify or clarify information submitted in support or as part of the annual report required under this paragraph. Parties shall submit such information within twenty-one days of request.

4. (a) The department shall conduct a preliminary review of all proposed transactions. Review of a material transaction notice may also, at the discretion of the department, consist of a full cost and market impact review. The department shall notify the parties if and when it determines that a full cost and market impact review is required and, if so, the date that the preliminary review is completed.

(b) In the event the department determines that a full cost and market impact review is required, the department shall have discretion to

require parties to delay the proposed transaction closing until such cost and market impact review is completed, but in no event shall the closing be delayed more than one hundred eighty days from the date the department completes its preliminary review of the proposed transaction.

(c) The department may assess on parties to a material transaction all actual, reasonable, and direct costs incurred in reviewing and evaluating the notice. Any such fees shall be payable to the department within fourteen days of notice of such assessment.

5. (a) The department may require that any party to a transaction, including any parents or subsidiaries thereof, submit additional documents and information in connection with a material transaction notice or a full cost and market impact review required under this section, to the extent such additional information is necessary to conduct a preliminary review of the transaction; to assess the impacts of the transaction on cost, quality, access, health equity, and competition; or to verify or clarify information submitted pursuant to subdivision one of this section. Parties shall submit such information within twenty-one days of request.

(b) The department shall keep confidential all nonpublic information and documents obtained under this subdivision and shall not disclose the information or documents to any person without the consent of the parties to the proposed transaction, except as set forth in paragraph (c) of this subdivision.

(c) Any data reported to the department pursuant to subdivision three of this section, any information obtained pursuant to paragraph (a) of this subdivision, and any cost and market impact review findings made pursuant to subdivision four of this section may be used as evidence in investigations, reviews, or other actions by the department or the office of the attorney general, including but not limited to use by the department in assessing certificate of need applications submitted by the same healthcare entities involved in the reported material transaction or unrelated parties which are located in the same market area identified in the cost and market impact review.

6. Except as provided in subdivision two of this section, documentation, data, and information submitted to the department as described in subdivisions one, three, and five of this section shall not be subject to disclosure under article six of the public officers law.

7. The commissioner shall promulgate regulations to effectuate this section.

8. Failure to [~~notify the department of a material transaction under~~] comply with any requirement of this section shall be subject to civil penalties under section twelve of this chapter. Each day in which the violation continues shall constitute a separate violation.

§ 2. This act shall take effect one year after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART T

Section 1. Paragraphs (a), (b), (c) and (d) of subdivision 1 of section 2805-i of the public health law are relettered paragraphs (d), (e), (f) and (g) and three new paragraphs (a), (b) and (c) are added to read as follows:

(a) Maintaining the following full-time, part-time, contracted, or on-call staff:

(1) One or more hospital sexual violence response coordinators who are designated to ensure that the hospital's sexual violence response is integrated within the hospital's clinical oversight and quality improvement structure and to ensure chain of custody is maintained;

(2) Sexual assault forensic examiners sufficient to meet hospital needs. Such individuals shall:

(i) be a registered professional nurse, certified nurse practitioner, licensed physician assistant or licensed physician acting within their lawful scope of practice and specially trained in forensic examination of sexual offense victims and the preservation of forensic evidence in such cases and certified as qualified to provide such services, pursuant to regulations promulgated by the commissioner; and

(ii) have successfully completed a didactic and clinical training course and post course preceptorship as appropriate to scope of practice that aligns with guidance released by the commissioner, provided that the commissioner is authorized to develop regulations allowing individuals to satisfy the requirements of this subparagraph in limited cases, pending the completion of a post course preceptorship.

(b) Ensuring that such sexual assault forensic examiners are on-call and available on a twenty-four hour a day basis every day of the year;

(c) Ensuring that such sexual assault forensic examiners maintain competency in providing sexual assault examinations;

§ 2. Paragraph (a) of subdivision 13 of section 631 of the executive law, as amended by section 3 of subpart S of part XX of chapter 55 of the laws of 2020, is amended to read as follows:

(a) Notwithstanding any other provision of law, rule, or regulation to the contrary, when any New York state accredited hospital, accredited sexual assault examiner program, or licensed health care provider furnishes services to any sexual assault survivor, including but not limited to a health care forensic examination in accordance with the sex offense evidence collection protocol and standards established by the department of health, such hospital, sexual assault examiner program, or licensed healthcare provider shall provide such services to the person without charge and shall bill the office directly. The office, in consultation with the department of health, shall define the specific services to be covered by the sexual assault forensic exam reimbursement fee, which must include at a minimum forensic examiner services, hospital or healthcare facility services related to the exam, and any necessary related laboratory tests or pharmaceuticals; including but not limited to HIV post-exposure prophylaxis provided by a hospital emergency room at the time of the forensic rape examination pursuant to paragraph [~~(c)~~] (f) of subdivision one of section twenty-eight hundred five-i of the public health law. For a person eighteen years of age or older, follow-up HIV post-exposure prophylaxis costs shall continue to be reimbursed according to established office procedure. The office, in consultation with the department of health, shall also generate the necessary regulations and forms for the direct reimbursement procedure.

§ 3. Paragraph (d) of subdivision 1 and paragraph (c) of subdivision 2 of section 2805-p of the public health law, as added by chapter 625 of the laws of 2003, are amended to read as follows:

(d) "Rape survivor" or "survivor" shall mean any [~~female~~] person who alleges or is alleged to have been raped and who presents as a patient.

(c) provide emergency contraception to such survivor, unless contraindicated, upon [~~her~~] such survivor's request. No hospital may be required to provide emergency contraception to a rape survivor who is pregnant.

§ 4. This act shall take effect immediately; provided, however, that subparagraph 2 of paragraph (a) of subdivision 1 of section 2805-i of the public health law, as added by section one of this act, shall take effect two years after this act shall have become a law.

PART U

Intentionally Omitted

PART V

Intentionally Omitted

PART W

Intentionally Omitted

PART X

Intentionally Omitted

PART Y

Section 1. Section 2803 of the public health law is amended by adding a new subdivision 15 to read as follows:

15. Subject to the availability of federal financial participation and notwithstanding any provision of this article, or any rule or regulation to the contrary, the commissioner may allow general hospitals to provide off-site acute care medical services, that are:

(a) not home care services as defined in subdivision one of section thirty-six hundred two of this chapter or the professional services enumerated in subdivision two of section thirty-six hundred two of this chapter; provided, however, that nothing shall preclude a hospital from offering hospital services as defined in subdivision four of section twenty-eight hundred one of this article;

(b) provided by a medical professional, including a physician, registered nurse, nurse practitioner, or physician assistant, to a patient with a preexisting clinical relationship with the general hospital, or with the health care professional providing the service;

(c) provided to a patient for whom a medical professional has determined is appropriate to receive acute medical services at their residence; and

(d) consistent with all applicable federal, state, and local laws, the general hospital has appropriate discharge planning in place to coordinate discharge to a home care agency where medically necessary and consented to by the patient after the patient's acute care episode ends.

(e) Nothing in this subdivision shall preclude off-site services from being provided in accordance with subdivision eleven of this section and department regulations.

(f) The department is authorized to establish medical assistance program rates to effectuate this subdivision. For the purposes of the department determining the applicable rates pursuant to such authority, any general hospital approved pursuant to this subdivision shall report to the department, in the form and format required by the department, its annual operating costs and statistics, specifically for such off-site acute services. Failure to timely submit such cost data to the department may result in revocation of authority to participate in a program under this section due to the inability to establish appropriate reimbursement rates.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025 and shall expire and be deemed repealed on April 1, 2027.

PART Z

Section 1. Section 4 of chapter 565 of the laws of 2022 amending the state finance law relating to preferred source status for entities that provide employment to certain persons, is amended to read as follows:

§ 4. This act shall take effect immediately; provided that section one of this act shall expire and be deemed repealed [~~three~~] five years after such effective date; and provided further that this act shall not apply to any contracts or requests for proposals issued by government entities before such date.

§ 2. Section 2 of chapter 91 of the laws of 2023 amending the state finance law relating to establishing a threshold for the amount of work needed to be performed by a preferred source which is an approved charitable non-profit-making agency for the blind, is amended to read as follows:

§ 2. This act shall take effect on the same date and in the same manner as a chapter of the laws of 2022, amending the state finance law relating to preferred source status for entities that provide employment to certain persons, as proposed in legislative bills numbers S. 7578-C and A. 8549-C, takes effect, and shall expire and be deemed repealed [~~three~~] five years after such effective date.

§ 3. This act shall take effect immediately.

PART AA

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 Z of chapter 57 of the laws of 2024, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, [~~2025~~] 2027.

§ 2. This act shall take effect immediately.

PART BB

Section 1. Section 4 of part L of chapter 59 of the laws of 2016, amending the mental hygiene law relating to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental

disabilities and/or chemical dependence, as amended by section 1 of part OO of chapter 57 of the laws of 2022, is amended to read as follows:

§ 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016; provided, however, that sections one and two of this act shall expire and be deemed repealed on March 31, [~~2025~~] **2027**.

§ 2. This act shall take effect immediately.

PART CC

Section 1. Subdivision 1-a of section 84 of part A of chapter 56 of the laws of 2013, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2013-2014 state fiscal year, as amended by section 1 of part EE of chapter 57 of the laws of 2023, is amended to read as follows:

1-a. sections seventy-three through eighty-a shall expire and be deemed repealed December 31, [~~2025~~] **2027**;

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART DD

Section 1. Subdivision (a) of section 22.11 of the mental hygiene law, as added by chapter 558 of the laws of 1999, is amended to read as follows:

(a) For the purposes of this section, the word "minor" shall mean a person under eighteen years of age, but does not include a person who is the parent of a child or has married or who is emancipated**, or is a homeless youth, as defined in section five hundred thirty-two-a of the executive law, or receives services at an approved runaway and homeless youth crisis services program or a transitional independent living support program as defined in section five hundred thirty-two-a of the executive law**.

§ 2. Paragraph 1 of subdivision (a) of section 33.21 of the mental hygiene law, as amended by chapter 461 of the laws of 1994, is amended to read as follows:

(1) "minor" shall mean a person under eighteen years of age, but shall not include a person who is the parent of a child, emancipated, has married or is on voluntary status on [~~his or her~~] **their** own application pursuant to section 9.13 of this chapter**, or is a homeless youth, as defined in section five hundred thirty-two-a of the executive law, or receives services at an approved runaway and homeless youth crisis services program or a transitional independent living support program as defined in section five hundred thirty-two-a of the executive law**;

§ 3. Subdivision 1 of section 2504 of the public health law, as amended by chapter 107 of the laws of 2023, is amended to read as follows:

1. Any person who is eighteen years of age or older, or is the parent of a child or has married, or is a homeless youth as defined in section five hundred thirty-two-a of the executive law, or receives services at an approved runaway and homeless youth crisis services program or a transitional independent living support program as defined in section five hundred thirty-two-a of the executive law, may give effective consent for medical, dental, health and hospital services**, and behavioral health services, including mental health care and substance use**

treatment, for themself, and the consent of no other person shall be necessary.

§ 4. This act shall take effect on the ninetieth day after it shall have become a law.

PART EE

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 6. Intentionally omitted.

§ 7. Intentionally omitted.

§ 8. The mental hygiene law is amended by adding a new section 9.64 to read as follows:

§ 9.64 Notice of admission determination to community provider.

Upon an admission to a hospital or received as a patient in a comprehensive psychiatric emergency program pursuant to the provisions of this article, the director of such hospital or program shall ensure that reasonable efforts are made to identify and promptly notify of such determination any community provider of mental health services that maintains such person on its caseload.

§ 9. Subdivision (f) of section 29.15 of the mental hygiene law, as amended by chapter 135 of the laws of 1993, is amended to read as follows:

(f) The discharge or conditional release of all clients at developmental centers, patients at psychiatric centers or patients at psychiatric inpatient services subject to licensure by the office of mental health shall be in accordance with a written service plan prepared by staff familiar with the case history of the client or patient to be discharged or conditionally released and in cooperation with appropriate social services officials and directors of local governmental units. In causing such plan to be prepared, the director of the facility shall take steps to assure that the following persons are interviewed, provided an opportunity to actively participate in the development of such plan and advised of whatever services might be available to the patient through the mental hygiene legal service: the patient to be discharged or conditionally released; **a representative of a community provider of mental health services, including a provider of case management services, that maintains the patient on its caseload;** an authorized representative of the patient, to include the parent or parents if the patient is a minor, unless such minor sixteen years of age or older objects to the participation of the parent or parents and there has been a clinical determination by a physician that the involvement of the parent or parents is not clinically appropriate and such determination is documented in the clinical record and there is no plan to discharge or release the minor to the home of such parent or parents; and upon the request of the patient sixteen years of age or older, [~~a significant~~] **an** individual **significant** to the patient including any relative, close friend or individual otherwise concerned with the welfare of the patient, other than an employee of the facility.

§ 10. This act shall take effect ninety days after it shall have become a law.

PART FF

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners and directors 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, office of victim services, department of health, and the state office for the aging (hereinafter "the commissioners") shall establish a state fiscal year 2025-2026 targeted inflationary increase (TII), effective April 1, 2025, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in subdivision five of this section. The TII 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, 2025, through March 31, 2026, the commissioners and directors shall provide funding to support a seven and eight-tenths percent (7.8%) targeted inflationary increase under this section for all eligible programs and services as determined pursuant to subdivision five of this section.

3. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 7.8 percent targeted inflationary increase (TII) established herein shall be inclusive of all other cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2025. Except for the 7.8 percent targeted inflationary increase (TII) established herein, for the period commencing on April 1, 2025, and ending March 31, 2026 the commissioners and directors shall not apply any other new cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other cost of living type increases, inflation factors, or trend factors" as defined in this subdivision shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic public health emergency. This subdivision shall not prevent the office of children and family services from applying additional trend factors or staff retention factors to eligible programs and services under paragraph (v) of subdivision five of this section.

4. Each local government unit or direct contract provider receiving the targeted inflationary increase established herein shall use such funding to provide a targeted salary increase of at least four percent (4.0%) to eligible individuals in accordance with subdivision six of this section. Notwithstanding any inconsistent provision of law, the commissioners and directors shall develop guidelines for local government units and direct contract providers on implementation of such targeted salary increase.

5. Eligible programs and services. (i) Programs and services funded, licensed, or certified by the office of mental health (OMH) eligible for the targeted inflationary increase 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 targeted inflationary increase established herein, pending federal approval where applicable, include: local/unified services; chapter 620 services; voluntary operated community residential services; article 16 clinics; day treatment services; family support services; 100% day training; epilepsy services; traumatic brain injury services; hepatitis B services; independent practitioner services for individuals with intellectual and/or developmental disabilities; crisis services for individuals with intellectual and/or developmental disabilities; family care residential habilitation; supervised residential habilitation; supportive residential habilitation; respite; day habilitation; prevocational services; supported employment; community habilitation; intermediate care facility day and residential services; specialty hospital; pathways to employment; intensive behavioral services; community transition services; family education and training; fiscal intermediary; support broker; and personal resource accounts. The office, in collaboration with the education department, shall also provide a comparable targeted inflationary increase to the independent living centers program.

(iii) Programs and services funded, licensed, or certified by the office of addiction services and supports (OASAS) eligible for the targeted inflationary increase 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 targeted inflationary increase established herein, pending federal approval where applicable, include: nutrition outreach and education program (NOEP); 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 targeted inflationary increase 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; child care resource and referral agencies; healthy families New York; maternal, infant, and early childhood home visiting (MIECHV) initiative; New York state learning and enrichment after-school program supports (LEAPS); 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 targeted inflationary increase established herein, pending federal approval where applicable, include: community services for the elderly; expanded in-home services for the elderly; wellness in nutrition program; New York connects program; long term ombudsman 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 department of health eligible for the targeted inflationary increase established herein, pending federal approval where applicable, include: health home care management agencies authorized under section 365-l of the social services law; rape crisis programs; and medicaid transportation program.

(viii) Programs and services funded, licensed, or certified by the office of victim services eligible for the targeted inflationary increase established herein, pending federal approval where applicable,

include: crime victim service programs as defined by section 631-a of the executive law.

6. Eligible individuals. Support staff, direct care staff, clinical staff, and non-executive administrative staff in programs and services listed in subdivision five of this section shall be eligible for the 4.0% targeted salary increase established pursuant to subdivision four of this section.

(a) For the office of mental health, office for people with developmental disabilities, and office of addiction services and supports, support staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 100 to 199; direct care staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 200 to 299; clinical staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 300 to 399; and non-executive administrative staff shall mean individuals employed in consolidated fiscal report position title codes 400, 500 to 599, 605 to 699, and 703 to 799. Individuals employed in consolidated fiscal report position title codes 601 to 604, 701 and 702 shall be ineligible for the 4.0% targeted salary increase established herein.

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

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

8. Notwithstanding any inconsistent provision of law to the contrary, agency commissioners and directors shall be authorized to recoup funding from a local governmental unit or direct contract provider for the targeted inflationary increase established herein determined to have been used in a manner inconsistent with the appropriation, or any other provision of this section. Such agency commissioners and directors 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, 2025.

PART GG

Section 1. Subdivisions 1 and 3 of section 368-d of the social services law, as amended by section 54 of part B of chapter 58 of the laws of 2009, are amended to read as follows:

1. The department of health shall review claims for expenditures made by or on behalf of local public school districts, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, for medical care, services and supplies which are furnished to children with handicapping conditions or such children suspected of having handicap-

ping conditions, as such children are defined in the education law. **The department of health shall also review claims for expenditures for early and periodic screening, diagnosis and treatment and other health services, care and supplies which are furnished to eligible children regardless of whether the children have handicapping conditions, are suspected of having handicapping conditions or have an individualized education plan.** If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such local public school district, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, which furnished the care, services or supplies either directly or by contract.

3. **The department of health shall apply for all necessary federal approvals to implement the provisions of this section.** The provisions of this section shall be of no force and effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this section.

§ 2. Subdivision 1 and the closing paragraph of section 368-e of the social services law, as amended by section 55 of part B of chapter 58 of the laws of 2009, are amended to read as follows:

1. The department of health shall review claims for expenditures made by counties and the city of New York for medical care, services and supplies which are furnished to preschool children with handicapping conditions or such preschool children suspected of having handicapping conditions, as such children are defined in the education law. **The department of health shall also review claims for expenditures for early and periodic screening, diagnosis and treatment and other health services, care and supplies which are furnished to eligible pre-school children regardless of whether the pre-school children have handicapping conditions, are suspected of having handicapping conditions or have an individualized education plan.** If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such county or city which furnished the care, services or supplies either directly or by contract. Notwithstanding any provisions of law, rule or regulation to the contrary, any clinic or diagnostic and treatment center licensed under article twenty-eight of the public health law, which as determined by the state education department, in conjunction with the department of health, has a less than arms length relationship with the provider approved under section forty-four hundred ten of the education law shall, subject to the approval of the department and based on standards developed by the department, be authorized to directly submit such claims for medical assistance, services or supplies so furnished for any period beginning on or after July first, nineteen hundred ninety-seven. The actual full cost of the individualized education program (IEP) related services incurred by the clinic shall be reported on the New York State Consolidated Fiscal Report in the education law section forty-four hundred ten program cost center in which the student is placed and the associated medical assistance revenue shall be reported in the same manner.

6. The department of health shall apply for all necessary federal approvals to implement the provisions of this section. The provisions of this section shall be of no force and effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this section.

§ 3. This act shall take effect immediately, and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART HH

Section 1. Section 30-a of the public health law is amended by adding three new subdivisions 4, 5 and 6 to read as follows:

4. "Overpayment" shall mean any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

5. "Applicable standards" shall mean the state laws, regulations and duly promulgated policies, guidelines, protocols and interpretations of state agencies with jurisdiction in effect at the time the provider engaged in the regulated conduct or provision of services that the inspector general is auditing or reviewing.

6. "Clerical or minor error or omission" shall include mathematical or computational mistakes; transposed procedure or diagnostic codes; inaccurate data entry; computer errors; duplicate claims; and incorrect data items, such as provider number, use of a modifier or date of service.

§ 2. The public health law is amended by adding a new section 37 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 to conduct such audit or review, shall comply with the following standards:

1. Any reviews or audits of provider contracts, cost reports, claims, bills or medical assistance payments shall apply the applicable standard. Prior to commencing an audit or review, the inspector shall provide to the provider access to any applicable standards. For the purpose of this subdivision, an applicable standard shall not be deemed in effect if federal governmental approval was pending or denied at the time the provider engaged in the regulated conduct or provision of services.

2. The inspector shall publish the most current version of 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 the Medicaid inspector general website in advance of commencing such audit or review, which protocols shall include any and all applicable standards.

3. In determining the amount of an overpayment a provider must repay following an audit or review, consistent with subdivision six of section thirty-two of this title, the inspector must consider the following factors:

(a) Whether the findings suggest a sustained or high level of payment error;

(b) Whether the nature of the error is a clerical or minor error or omission;

(c) Impacts to the provider's financial solvency; and

(d) The potential for the repayment, if ordered, to negatively impact access to services.

4. Any sampling and extrapolation methodologies utilized by the inspector shall be consistent with accepted standards of sound auditing practice and statistical analysis.

5. If the inspector determines that the basis of an overpayment is a clerical or minor error or omission, and if the inspector further determines such clerical or minor error or omission are isolated occurrences, limited to three or less, then the inspector shall not apply extrapolation in those cases and recoupment will be limited to each such affected audited claim.

6. The draft audit report given to the provider shall include the inspector's findings and a detailed written explanation of the extrapolation method if used, 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 to calculate the alleged overpayment and any applicable offset based on the sample results.

7. The inspector shall consider any supporting documentation that the provider submits prior to the issuance of the final audit report that the provider thinks is relevant to the audit, including, but not limited to attestations addressing missing documentation and/or signatures. The inspector shall use the totality of the record to determine if the documentation or signature requirement, as outlined in statute or regulation, is met, and/or consider submitted attestations to resolve the issue. If the inspector rejects such supporting documentation, an explanation for such rejection shall be provided in writing.

8. The inspector's final audit report or final notice of agency action shall include a specific explanation of the inspector's consideration of the factors described in paragraphs (a) through (d) of subdivision three of this section.

9. The inspector shall not foreclose or prohibit the provider from settling through repayment at the lower confidence limit plus applicable interest, even if the provider requests a hearing, up until the hearing determination is issued.

10. Neither recoupment by the inspector nor repayment by the provider of overpayments shall commence earlier than sixty days from the issuance date of the final audit report or, if the provider requests a hearing, then sixty days from the issuance date of the hearing determination.

11. Nothing in this section shall prevent the inspector from complying with Medicaid audit requirements established by federal law, rules and regulations, or binding federal agency guidance and directives.

§ 3. The opening paragraph of subdivision 1 of section 35 of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

The inspector shall, no later than October first of each year, [~~submit~~] consult with the commissioner on the preparation of an annual report, to be made and filed by the inspector and submitted 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, the commissioner of the office of persons with developmental disabilities, the state comptroller and the attorney general[~~, a report~~

~~summarizing the activities of the office during the preceding calendar year~~]. Such report shall include:

§ 4. Paragraphs (b), (f) and (g) of subdivision 1 of section 35 of the public health law, paragraph (b) as added by chapter 442 of the laws of 2006, paragraph (f) as amended and paragraph (g) as added by section 111 of part E of chapter 56 of the laws of 2013, are amended and a new paragraph (h) is added to read as follows:

(b) the number, subject and other relevant characteristics of audits initiated, and those completed, including but not limited to outcome, region, reason for audit and the total dollar value identified for recovery [~~and~~]**,** the actual recovery from such audits **and how many audits where overpayments were recovered used extrapolation**;

(f) a narrative that evaluates the office's performance, describes any specific problems and connection with the procedures and agreements required under this section, discusses any other matters that may have impaired its effectiveness and summarizes the total savings to the state's medical assistance program; [~~and~~]

(g) a narrative, provided by the department in its annual report pursuant to paragraph (t) of subdivision one of section two hundred six of this chapter that summarizes the department's activities to mitigate fraud, waste and abuse during the preceding calendar year[~~.~~]**; and**

(h) a narrative that describes the steps taken by the office in the past year to comply with subdivision six of section thirty-two of this title, which requires consideration of quality and availability of medical and long term care and services and the best interest of both the medical assistance program and recipients, in the pursuit of civil and administrative enforcement actions.

§ 5. This act shall take effect April 1, 2026.

PART II

Section 1. Legislative findings. The legislature finds that since 2003 more than 40 community hospitals in New York state have closed.

The legislature additionally finds that as a result of hospital consolidation, large health care systems now control more than 70 percent of acute hospital beds in the state and that these systems sometimes remove categories of care from local hospitals, leaving patients in regions of the state without access to particular types of care, including some types of emergency care.

The legislature further finds that patients do not have the ability to determine whether health care facilities in their area provide the care they seek, because information about how facility restrictions impact options for care is too difficult to obtain.

The legislature also finds that denials and poor access to care can lead to serious adverse health impacts that jeopardize individuals' lives and wellbeing and that New York needs to understand health care gaps and their impact statewide.

Finally, the legislature finds that some denials of care violate state and federal law.

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

§ 2803-bb. Hospital rule-based exclusions. 1. As used in this section, "hospital rule-based exclusions" means any criteria, rules, or policies, whether written or unwritten, formally adopted or drafted, endorsed by the general hospital or followed from an external source, that restrict a general hospital from providing types of care that the

general hospital is licensed to provide or that restrict the provision of care to categories of patients on the basis of any characteristic protected under section two hundred ninety-six of the executive law that the general hospital is licensed to provide. "Hospital rule-based exclusions" shall include, but not be limited to, objections under section twenty-nine hundred eighty-four or twenty-nine hundred ninety-four-n of this chapter. "Hospital rule-based exclusions" shall not include restrictions based on lack of equipment, available bed space in the facility, or insurance denial.

2. (a) The commissioner shall collect from each general hospital a list of its hospital rule-based exclusions on an annual basis. Each general hospital shall furnish a list of hospital rule-based exclusions to the department, immediately upon request.

(b) The commissioner shall publish on the department's website a current list of all of the general hospitals with hospital rule-based exclusions and the hospital rule-based exclusions for each general hospital not later than six months after the effective date of this section. The commissioner shall update this list on an annual basis. The commissioner, in consultation with experts in health care access, patient advocacy, types of health care that are frequently inaccessible, and hospital administration shall promulgate rules and regulations creating standardized language for this list to ensure that it is readily understandable to patients, prospective patients, and members of the public.

(c) Within one year of the effective date of this section and every five years thereafter, the commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly regarding hospital rule-based exclusions in the state and the impact of such hospital rule-based exclusions on patients' ability to access quality, comprehensive, affordable care near their residences and whether and how access to care varies by community, as well as by race, gender, ethnicity, sexual orientation, gender identity or gender expression, and socioeconomic status, across the state. The report shall be made publicly available on the department's website.

(d) The commissioner may promulgate rules and regulations as may be necessary and proper to carry out effectively the provisions of this section.

§ 3. Subdivision 1 of section 2803 of the public health law is amended by adding a new paragraph (m) to read as follows:

(m) The statement regarding patient rights and responsibilities, required pursuant to paragraph (g) of this subdivision, shall include an explanation of hospital rule-based exclusions and a link to the section of the department's website required in paragraph (b) of subdivision two of section twenty-eight hundred three-bb of this article. Each general hospital's website shall prominently link to the department's website required in paragraph (b) of subdivision two of section twenty-eight hundred three-bb of this article. The commissioner may promulgate rules and regulations as may be necessary and proper to carry out effectively the provisions of this paragraph.

§ 4. Subsection (a) of section 3217-a of the insurance law is amended by adding a new paragraph 22 to read as follows:

(22)(A) an explanation of hospital rule-based exclusions and the fact that some general hospitals may have hospital rule-based exclusions, along with a link to the website required pursuant to subdivision two of section twenty-eight hundred three-bb of the public health law.

(B) for the purposes of this paragraph, "hospital rule-based exclusions" shall have the same meaning as in section twenty-eight hundred three-bb of the public health law.

§ 5. Subsection (a) of section 4324 of the insurance law is amended by adding a new paragraph 23 to read as follows:

(23)(A) an explanation of hospital rule-based exclusions and the fact that some general hospitals may have hospital rule-based exclusions, along with a link to the website required pursuant to subdivision two of section twenty-eight hundred three-bb of the public health law.

(B) for the purposes of this paragraph, "hospital rule-based exclusions" shall have the same meaning as in section twenty-eight hundred three-bb of the public health law.

§ 6. Subdivision 1 of section 4408 of the public health law is amended by adding a new paragraph (w) to read as follows:

(w) (i) An explanation of hospital rule-based exclusions and the fact that some general hospitals may have hospital rule-based exclusions, along with a link to the website required pursuant to subdivision two of section twenty-eight hundred three-bb of this chapter.

(ii) For the purposes of this paragraph, "hospital rule-based exclusions" shall have the same meaning as in section twenty-eight hundred three-bb of this chapter.

§ 7. Nothing in this act shall be construed to permit or authorize denials of care or discrimination in the provision of health care or health insurance. Compliance with this act does not reduce or limit any liability for general hospitals in connection with hospital rule-based exclusions, including violations of state or federal law.

§ 8. Severability clause. If any provision of this act, or any application of any provision of this act, is held to be invalid, or ruled to violate or be inconsistent with any applicable federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this act, or of any other application of any provision of this act. 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.

§ 9. This act shall take effect eighteen months after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART JJ

Section 1. Short title. This act shall be known and may be cited as the "Sickle Cell Treatment Act".

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

§ 2807-bb. Sickle cell centers for excellence and outpatient treatment centers. 1. Centers for sickle cell care excellence. The commissioner shall designate five general hospitals or hospices with a minimum of two centers north of Putnam and Orange counties under article forty of this chapter, upon successful application, as centers for sickle cell care excellence. The designations shall be made through an application designed by the department, and based on service, staffing and other criteria as developed by the commissioner. The centers of excellence shall provide specialized sickle cell disease care, treatment, palliative care, education and related services and shall conduct specialized

research into the care, treatment and management of sickle cell disease. Designation as a center for sickle cell care excellence shall not entitle a center to enhanced reimbursement, but may be utilized in outreach and other promotional activities. Each center for sickle cell care excellence shall affiliate and cooperate with major centers of higher learning, including medical colleges, and life science research institutes in the state. The state university shall enter into appropriate legal agreements to enable this cooperation. Each center for sickle cell care excellence shall receive five hundred thousand dollars per year from the department, from amounts appropriated for that purpose, to be used on sickle cell disease research.

2. Outpatient treatment centers. The commissioner shall designate ten hospitals, distributed based on sickle cell patient population concentrations, as sickle cell outpatient treatment centers which shall provide patients treatment for sickle cell disease as an outpatient. Each sickle cell outpatient treatment center shall receive two hundred fifty thousand dollars per year from the department, from amounts appropriated for that purpose, to be used to ensure the proper management and equipping of the centers to care for sickle cell patients.

§ 3. Subdivision 8 of section 3331 of the public health law, as added by section 7-a of part D of chapter 57 of the laws of 2018, is amended to read as follows:

8. No opioids shall be prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than three months or past the time of normal tissue healing, unless the medical record contains a written treatment plan that follows generally accepted national professional or governmental guidelines. The requirements of this [~~paragraph~~] subdivision shall not apply in the case of patients who are being treated for sickle cell disease or cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

§ 4. This act shall take effect immediately and shall be deemed to be in full force and effect on and after April 1, 2025.

PART KK

Section 1. Article 2-A of the public health law is amended by adding a new title IV to read as follows:

TITLE IV

PRESERVING ACCESS TO AFFORDABLE DRUGS

Section 282. Definitions.

283. Preserving access to affordable drugs.

§ 282. Definitions. For the purposes of this title, the following terms shall have the following meanings:

1. "ANDA" shall mean abbreviated new drug application as described by 505(j) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 335(j).

2. "ANDA filer" shall mean a party that owns or controls an ANDA filed with the federal food and drug administration or has the exclusive rights under that ANDA to distribute the ANDA product.

3. "Agreement" shall mean anything that would constitute an agreement under state law.

4. "Agreement resolving or settling a patent infringement claim" includes any agreement that is entered into within thirty days of the resolution or the settlement of the claim, or any other agreement that is contingent upon, provides a contingent condition for, or is otherwise

related to the resolution or settlement of the claim. This shall include, but is not limited to, the following:

(a) Any agreement required to be provided to the federal trade commission or the antitrust division of the United States Department of Justice under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173;

(b) Any agreement between a biosimilar or interchangeable product applicant and a reference product sponsor under the Biologics Price Competition and Innovation Act of 2009, Pub. L. No. 111-148, that resolves patent claims between the applicant and sponsor.

5. "Biosimilar biological product application filer" shall mean a party that owns or controls a biosimilar biological product application filed with the federal food and drug administration pursuant to section 351(k) of the Public Health Service Act, 42 U.S.C. 262(k), for licensure of a biological product as biosimilar to, or interchangeable with, a reference product, or that has the exclusive rights under the application to distribute the biosimilar biological product.

6. "NDA" shall mean a new drug application.

7. "Nonreference drug filer" shall mean either:

(a) An ANDA filer;

(b) A company that seeks an abbreviated approval pathway for its drug product under 505(b)(2) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(b)(2); or

(c) A biosimilar biological product application filer, or company seeking FDA approval for a biosimilar under 42 U.S.C. 262.

8. "Nonreference drug product" shall mean the product to be manufactured under an ANDA or an application filed under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(b), that is the subject of the patent infringement claim, a biosimilar biological product that is the product to be manufactured under the biosimilar biological product application that is the subject of the patent infringement claim, or both.

9. "Patent infringement" shall mean infringement of any patent or of any filed patent application, extension, reissue, renewal, division, continuation, continuation in part, reexamination, patent term restoration, patents of addition, and extensions thereof.

10. "Patent infringement claim" shall mean any allegation made to a nonreference drug filer, whether or not included in a complaint filed with a court of law, that its nonreference drug product or application infringes any patent held by, or exclusively licensed to, the reference drug holder.

11. "Reference drug holder" shall mean either:

(a) A brand holder that is any of the following:

(i) The holder of an approved NDA for a drug product application filed under section 505(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(b);

(ii) A person owning or controlling enforcement of the patent listed in the approved drug products with therapeutic equivalence evaluations in connection with the NDA; or

(iii) The predecessors, subsidiaries, divisions, groups, and affiliates controlled by, controlling, or under common control with, any of the entities described in subparagraph (i) or (ii) of this paragraph, with control to be presumed by direct or indirect share ownership of fifty percent or greater, as well as the licensees, licensors, successors, and assigns of each of those entities; or

(b) A biological product license holder, which shall mean any of the following:

(i) The holder of an approved biological product license application for a biological drug product under section 351(a) of the Public Health Service Act, 42 U.S.C. 262(a);

(ii) A person owning or controlling enforcement of any patents that claim the biological product that is the subject of the approved biological patent license application; or

(iii) The predecessors, subsidiaries, divisions, groups, and affiliates controlled by, controlling, or under common control with, any of the entities described in subparagraph (i) or (ii) of this paragraph, with control to be presumed by direct or indirect share ownership of fifty percent or greater, as well as the licensees, licensors, successors, and assigns of each of those entities.

12. "Reference drug product" shall mean the product to be manufactured by the reference drug holder and includes both branded drugs of the NDA holder and the biologic drug product of the biologic product license applicant.

13. "Statutory exclusivity" shall mean those prohibitions on the approval of drug applications under clauses (ii) through (iv) of section 505(c)(3)(E), section 527 or section 505A of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c)(3)(E), on the licensing of biological product applications under section 262(k)(7) of Title 42 of the United States Code or section 262(m)(2) or (3) of Title 42 of the United States Code.

§ 283. Preserving access to affordable drugs. 1. (a) Except as provided in paragraph (c) of this subdivision, an agreement resolving or settling, on a final or interim basis, a patent infringement claim, in connection with the sale of a pharmaceutical product, shall be presumed to have anticompetitive effects and shall be a violation of this section if both of the following apply:

(i) A nonreference drug filer receives anything of value from another company asserting patent infringement, including, but not limited to, an exclusive license or a promise that the brand company will not launch an authorized generic version of its brand drug; and

(ii) The nonreference drug filer agrees to limit or forego research, development, manufacturing, marketing, or sales of the nonreference drug filer's product for any period of time.

(b) As used in subparagraph (i) of paragraph (a) of this subdivision, "anything of value" shall be interpreted broadly to include any type of consideration, value or benefit a reference drug holder or nonreference drug filer could possibly obtain from the agreement. "Anything of value" shall not include a settlement of patent infringement claims in which the consideration granted by the reference drug holder to the nonreference drug filer as part of the resolution or settlement consists of only one or more of the following:

(i) The right to market the competing product in the United States before the expiration of either:

(A) A patent that is the basis for the patent infringement claim; or

(B) A patent right or other statutory exclusivity that would prevent the marketing of the drug;

(ii) A covenant not to sue on a claim that the nonreference drug product infringes a United States patent;

(iii) Compensation for saved reasonable future litigation expenses of the reference drug holder but only if both of the following are true:

(A) The total compensation for saved litigation expenses is reflected in budgets that the reference drug holder documented and adopted at least six months before the settlement; and

(B) The compensation shall not exceed the lower of the following:

(1) Seven million five hundred thousand dollars; or

(2) Five percent of the revenue that the nonreference drug filer projected or forecasted it would receive in the first three years of sales of its version of the reference drug documented at least twelve months before the settlement. If no projections or forecasts are available, the compensation shall not exceed two hundred fifty thousand dollars;

(iv) An agreement by the reference drug holder not to interfere with the nonreference drug filer's ability to secure and maintain regulatory approval to market the nonreference drug product or an agreement to facilitate the nonreference drug filer's ability to secure and maintain regulatory approval to market the nonreference drug product; or

(v) An agreement resolving a patent infringement claim in which the reference drug holder forgives the potential damages accrued by a nonreference drug filer for an at-risk launch of the nonreference drug product that is the subject of that claim.

(c) Parties to an agreement are not in violation of paragraph (a) of this subdivision if they can demonstrate by clear and convincing evidence that either of the following are met:

(i) The value received by the nonreference drug filer described in subparagraph (i) of paragraph (a) of this subdivision is a fair and reasonable compensation solely for other goods or services that the nonreference drug filer has promised to provide; or

(ii) The agreement has directly generated procompetitive benefits and the procompetitive benefits of the agreement outweigh the anticompetitive effects of the agreement.

2. In determining whether the parties to the agreement have met their burden under paragraph (c) of subdivision one of this section, a court of competent jurisdiction shall not consider any of the following:

(a) That entry into the marketplace could not have occurred until the expiration of the relevant patent exclusivity or that the agreement's provision for entry of the nonreference drug product before the expiration of any patent exclusivity means that the agreement is procompetitive within the meaning of subparagraph (ii) of paragraph (c) of subdivision one of this section;

(b) That any patent is enforceable and infringed by the nonreference drug filer in the absence of a final adjudication binding on the filer of those issues;

(c) That the agreement caused no delay in entry of the nonreference drug filer's drug product because of the lack of Federal Food and Drug Administration (FDA) approval of that or of another nonreference drug product; or

(d) That the agreement caused no harm or delay due to the possibility that the nonreference drug filer's drug product might infringe some patent that has not been asserted against the nonreference drug filer or that is not subject to a final and binding adjudication on that filer as to the patent's scope, enforceability, and infringement.

3. In determining whether the parties to the agreement have met their burden under paragraph (c) of subdivision one of this section, a court of competent jurisdiction shall presume that the relevant product market is that market consisting of the reference drug of the company alleging patent infringement and the drug product of the nonreference drug filer

accused of infringement and any other biological product that is licensed as biosimilar or is an AB-rated generic to the reference product.

4. (a) This section shall not modify, impair, limit, or supersede the applicability of the antitrust laws of the state pursuant to article twenty-two of the general business law, unfair competition laws of the state pursuant to article twenty-two-A of the general business law or the availability of damages or remedies provided therein. This section shall not modify, impair, limit, or supersede the right of any drug company applicant to assert claims or counterclaims against any person, under the antitrust laws or other laws relating to unfair competition of the federal antitrust law or state law.

(b) If any provision of this subdivision, an amendment made to this subdivision, or the application of any provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this subdivision, the amendments made to this subdivision, and the application of the provisions of this subdivision or amendments to any person or circumstance shall not be affected.

5. (a)(i) Each person that violates or assists in the violation of this section shall forfeit and pay to the state a civil penalty sufficient to deter violations of this section, as follows:

(A) If the person who violated this section received any value due to that violation, an amount up to three times the value received by the party that is reasonably attributable to the violation of this section, or twenty million dollars, whichever is greater; or

(B) If the violator has not received anything of value as described in this subparagraph, an amount up to three times the value given to other parties to the agreement reasonably attributable to the violation of this section, or twenty million dollars.

(C) For purposes of this subdivision, "reasonably attributable to the violation" shall be determined by the state's share of the market for the brand drug at issue in the agreement.

(ii) Any penalty described in subparagraph (i) of this paragraph shall accrue only to the state and shall be recovered in a civil action brought by the attorney general in its own name, or by any of its attorneys designated by it for that purpose, against any party to an agreement that violates this section.

(b) Each party that violates or assists in the violation of this section shall be liable for any damages, penalties, costs, fees, injunctions, or other equitable or legal remedies, including, but not limited to, restitution and disgorgement, that may be just and reasonable. Such remedies shall include, but not be limited to, any remedy available under articles twenty-two or twenty-two-A of the general business law and section sixty-three of the executive law.

(c) If the state is awarded penalties under subparagraph (i) of paragraph (a) of this subdivision, it shall not recover penalties pursuant to another law identified in paragraph (b) of this subdivision. This section shall not be construed to foreclose the state's ability to claim any equitable or legal remedy available in paragraph (b) of this subdivision.

(d) An action to enforce a cause of action for a violation of this section shall be commenced within six years after the cause of action accrued.

§ 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 or unenforceable, 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 on the sixtieth day after it shall have become a law.

PART LL

Section 1. Short title. This act shall be known and may be cited as "Daniel's law".

§ 2. Legislative findings and intent. It is the purpose of this act to promote the public health, safety and welfare of all citizens by broadly ensuring a public health-based response to anyone in New York experiencing a mental health, alcohol use or substance use crisis; to offer and ensure the most appropriate response to, and treatment of, individuals experiencing crisis due to mental health conditions, alcohol use or substance use conditions; and to deescalate crisis situations so that as few New Yorkers as possible experience nonconsensual transport, use of force, or criminal consequences as a result of mental health, alcohol use or substance abuse crises. The necessity to establish a defined response protocol for behavioral health and substance use crises has never been more urgent.

§ 3. Section 41.01 of the mental hygiene law, as amended by chapter 37 of the laws of 2011, is amended to read as follows:

§ 41.01 Declaration of purpose.

(a) This article is designed to enable and encourage local governments to develop in the community preventive, rehabilitative, **crisis response,** and treatment services offering continuity of care; to improve and to expand existing community programs for persons with mental illness, **and** developmental disabilities, and those [~~**suffering from the diseases of alcoholism**~~] **with alcohol use disorder** and substance [~~**abuse**~~] **use disorder**; to plan for the integration of community and state services and facilities for individuals with mental disabilities**, alcohol use disorders, and substance use disorders**; and to cooperate with other local governments and with the state in the provision of joint services and sharing of [~~**manpower**~~] **personnel** resources.

(b) Effective implementation of this article requires the [~~**direction**~~] **establishment** and administration, by each local governmental unit, of a local comprehensive planning process for its geographic area in which all providers of services shall participate and cooperate in the provision of all necessary information. [~~**It**~~] **This article** also initiates a planning effort involving the state, local governments and other providers of service for the purpose of promoting continuity of care through the development of integrated systems of care and treatment for individuals with mental illness, developmental disabilities, and for those [~~**suffering from the diseases of alcoholism**~~] **with alcohol use disorder** and substance [~~**abuse**~~] **use disorder**.

(c) Such planning effort must also specifically address the development of an effective crisis response system that includes the use of non-police, community-run crisis first responder teams utilizing peers and independent emergency medical technicians as first responders. To ensure the development of a comprehensive and inclusive plan, the crisis services planning effort must include at least fifty-one percent peers

and family peers, and the remaining forty-nine percent must be family members and emergency medical response providers who shall be independent of any local government's emergency services department, and operated by a non-governmental organization via a contract with the local government providers of crisis services, 9-8-8 personnel, and other non-governmental community agencies which may come in contact with a person experiencing a mental health or alcohol use or substance use crisis.

§ 4. Section 41.03 of the mental hygiene law is amended by adding six new subdivisions 14, 15, 16, 17, 18 and 19 to read as follows:

14. "emergency and crisis services plan" means a plan which is part of, and submitted with, the local services plan, but is planned and developed specifically to ensure that all services, policies, training, procedures, expenditures and contracts for services and processes used to assist people experiencing mental health or alcohol use or substance use crises are peer-focused, designed to decrease contact with police and centered on increased access to care of the highest quality.

15. "eligible emergency and crisis response services" means services eligible for funding under section 41.18 of this article, including but not limited to, crisis response teams, crisis stabilization services and centers, peer living rooms, peer support centers, mobile crisis teams not utilizing law enforcement as part of the team, crisis collaboratives, peer crisis services, and crisis system oversight and management, which are included in an emergency and crisis services plan.

16. "crisis response team" means one extensively-trained peer acting as a crisis worker and one emergency medical technician independent of any local government's emergency services department, and operated by a non-governmental agency via a contract with the local government.

17. "peer" means an individual with lived mental health experience and/or alcohol use or substance use disorder experience, who has experience navigating systems such as the healthcare, mental health, judicial, criminal legal, housing, education, and employment systems.

18. "family peer" means an individual with lived experience as the biological, foster, or adoptive parent, or the primary caregiver, of children/youth with social, emotional, behavioral, mental health or alcohol use or substance use disorders, who have experience navigating systems such as the healthcare, mental health, judicial, criminal legal, housing, education, and employment systems.

19. "statewide emergency and crisis response council" means the council created pursuant to section 5.08 of this chapter.

§ 5. Section 41.07 of the mental hygiene law is amended by adding a new subdivision (d) to read as follows:

(d) In developing the emergency and crisis services plan defined by subdivision fourteen of section 41.03 of this article and mandated by paragraph seventeen of subdivision (a) of section 41.13 of this article, local governments are encouraged to develop joint plans for a regional or sub-regional service area to maximize the use and availability of crisis and emergency services for all persons experiencing a mental health or alcohol use or substance use crisis in that region or sub-region.

§ 6. Subdivision (a) of section 41.13 of the mental hygiene law is amended by adding a new paragraph 17 to read as follows:

17. submit an emergency and crisis services plan, either alone or with other local governments in a region or sub-region, as required by subdivision fourteen of section 41.03 of this article to comprehensively plan for emergency and crisis services as is required by this chapter.

(i) The emergency and crisis services planning process shall include peers, family peers, family members, emergency medical response providers, 9-8-8 personnel and personnel of other community agencies which may come in contact with a person experiencing a mental health or alcohol use or substance use crisis. Peers and family peers shall constitute at least fifty-one percent of the planning group.

(ii) The emergency and crisis services plan shall be consistent with the commissioner's regulations for crisis services plans, developed pursuant to subdivision (f) of section 5.05 of this chapter after consultation with the statewide emergency and crisis response council.

§ 7. Subdivision (b) of section 41.18 of the mental hygiene law is amended by adding a new paragraph (vi) to read as follows:

(vi) Notwithstanding any other provision of this subdivision, local governments, individually or jointly, shall be granted state aid of one hundred percent of the net operating costs expended by such local governments, and by voluntary agencies which have contracted with such local governments, for eligible emergency and crisis services as defined by subdivision fifteen of section 41.03 of this article that are included in an approved emergency and crisis services plan. Funding provided pursuant to this paragraph shall be authorized only for services that have a non-police, non-law enforcement, or non-criminal legal component and include peers.

§ 8. Section 5.05 of the mental hygiene law is amended by adding five new subdivisions (f), (g), (h), (i) and (j) to read as follows:

(f) The commissioner of mental health and the commissioner of the office of addiction services and supports shall be jointly responsible for developing and revising as necessary, in regulation, specific standards and procedures for the operation and financing of crisis and emergency services, after consultation with the statewide emergency and crisis response council. Such standards and procedures shall require that the emergency and crisis services plans include a comprehensive approach to oversee and measure the approved plan's effectiveness in delivering high-quality, peer-focused crisis services, including response time standards, and periodic reporting requirements. The commissioners shall require specific metrics that approved plans shall utilize to evaluate system progress, effectiveness, and appropriate response times to crises, which shall be the same as or less than current response times for other health crises.

(g) The commissioner of mental health and the commissioner of the office of addiction services and supports shall be jointly responsible to ensure that:

(1) a non-police, community-run public health-based response that utilizes trained peer and independent emergency medical technician crisis response teams for anyone experiencing a mental health, alcohol use or substance use crisis is established. Any crisis response team may request that a peace officer as defined by section 2.10 of the criminal procedure law, or police officer as defined by section 1.20 of the criminal procedure law, transport a person in distress due to mental health conditions or alcohol use or substance use, when such team has exhausted alternative methods for obtaining consent from such person, such person refuses treatment or transport from the crisis response team; and:

(i) such person poses a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of imminent serious physical harm; or

(ii) such crisis response team makes an assessment, in light of the totality of the circumstances, that the crisis response team is at risk of imminent physical violence due to the person's actions;

(2) the crisis response teams operate twenty-four hours a day, three hundred sixty-five days a year;

(3) the crisis response teams receive culturally competent, trauma-informed, experientially-based, and peer-led training;

(4) the average response time for the crisis response teams is the same as or less than the current response time for other health crises;

(5) the crisis response teams de-escalate any situation involving individuals experiencing crisis due to mental health conditions, alcohol use, or substance use and avoid the use of nonconsensual treatment, transport, or force wherever possible;

(6) the most appropriate treatment is provided to individuals experiencing a mental health, alcohol use or substance use crisis;

(7) voluntary assessment and referral of individuals experiencing a mental health, alcohol use or substance use crisis are maximized;

(8) arrest, detention, and contact with the criminal legal system of individuals experiencing a mental health, alcohol use or substance use crisis are minimized;

(9) the number of individuals who experience physical harm and/or trauma as a result of a mental health, alcohol use or substance use crisis are minimized;

(10) 9-8-8 personnel respond to individuals experiencing a mental health, alcohol use or substance use crisis and are optimally utilized and integrated in the emergency and crisis services plan;

(11) a detailed plan to manage, oversee, monitor and regularly report on the operation of the proposed crisis response system which meets the requirements for these activities as required by subdivision (i) of this section is established;

(12) whenever an emergency hotline in New York state, such as 911 or 311, receives a call regarding an individual experiencing a mental health, alcohol use or substance use crisis, such hotline will refer such call to the crisis response team for the relevant geographic area; and

(13) the crisis response teams effectively respond to all individuals experiencing a mental health, alcohol use or substance use crisis with culturally competent, trauma-informed care and without regard to source of funding.

(h) (1) Within twelve months after the effective date of this subdivision, the commissioner of mental health and the commissioner of the office of addiction services and supports shall select an independent organization to conduct an evaluation of the statewide impact of the emergency and crisis response services mandated by this section on:

(i) the number of calls to, and responses sent by, dispatch services including 311, 911, and 988 in response to people experiencing mental health, alcohol use, or substance use crises;

(ii) the types of crises responded to;

(iii) the disposition and brief description of the result of each such call, anonymized to protect individuals' privacy;

(iv) demographic information including the race, ethnicity, gender, disability, and age of any individual who is the subject of any dispatch call or interaction by a local crisis response team;

(v) the details and destination of transport of any person experiencing a mental health, alcohol use or substance use crisis;

(vi) the services provided to such individuals;

(vii) the impact of emergency and crisis response services mandated by this section on emergency room visits, use of ambulatory services, hospitals as defined in article twenty-eight of the public health law and/or mental health facilities as defined in section 1.03 of the mental hygiene law; and

(viii) the involvement of law enforcement in mental health, alcohol use or substance use crises, including any use of force or restraint tactics or devices.

(2) The commissioner of mental health and the commissioner of the office of addiction services and supports shall direct the organization selected under paragraph one of this subdivision to issue its evaluation within six months of the first operating date of any approved regional emergency and crisis services plan, and shall include data from any regional plan then approved and operating in the state. Such evaluation shall be made publicly available and posted on the department's website upon receipt by such commissioners. In addition to the reporting requirements established pursuant to paragraph one of this subdivision, the commissioner of mental health and the commissioner of addiction services and supports shall collect all data listed under paragraph one of this subdivision, and shall report such data in a form and manner that is accessible to the public via the department's website. The first data report required by this paragraph, after the effective date of this subdivision, shall be made public within ninety days of the approval of any regional emergency and crisis response plan, and shall be made public in an ongoing manner every ninety days thereafter and include data from every active regional emergency and crisis response plan approved by the commissioners of mental health and the commissioner of addiction services and supports.

(3) No later than twelve months after the approval by the commissioner of mental health and the commissioner of the office of addiction services and supports of any regional emergency and crisis response plan, the commissioner of mental health and the commissioner of the office of addiction services and supports shall prepare a comprehensive report to the governor and the legislature specifying:

(i) the results of the evaluation carried out under paragraph one of this subdivision;

(ii) the number of individuals who received qualifying community-based crisis response services;

(iii) demographic information regarding such individuals when available, including the race, ethnicity, age, disability, sex, sexual orientation, gender identity, and geographic location of such individuals;

(iv) the processes and models developed by local governments in their emergency and crisis services plans to provide community-based crisis response services, including the processes developed to provide referrals for, or coordination with, follow-up care and services;

(v) the diversion of individuals from jails, incarceration, or similar settings;

(vi) the diversion of individuals from psychiatric hospitals, commitments under chapter four hundred eight of the laws of nineteen hundred ninety-nine, constituting Kendra's law, and other involuntary services;

(vii) the experiences of individuals who receive community-based crisis response services;

(viii) the successful connection of individuals with follow-up services;

(ix) the utilization of services by underserved and historically excluded communities, including black, indigenous and people of color (BIPOC) populations;

(x) the cost or cost savings attributable to such emergency and crisis response services;

(xi) other relevant outcomes identified by the commissioner of mental health and the commissioner of addiction services and supports and the statewide advisory emergency and crisis response council;

(xii) how all on-going aspects of assessment compare with the historical measures of such assessments; and

(xiii) recommendations for improvements to the emergency and crisis services systems throughout the state.

(4) All reports and evaluations conducted by the commissioner of mental health and the commissioner of the office of addiction services and supports shall be made publicly available, including on the website of the department.

(i) The commissioners of mental health and the commissioner of the office of addiction services and supports and the council created pursuant to section 5.08 of this article, shall be jointly responsible for approval of the emergency and crisis services plan component of a local services plan submitted by one or more local governmental units. Each plan shall have an attestation that such plan was developed as prescribed in paragraph seventeen of subdivision (a) of section 41.13 of this chapter to be considered for approval. Such approval shall serve as the basis for funding eligible emergency and crisis services pursuant to paragraph (vi) of subdivision (b) of section 41.18 of this chapter.

(j) The commissioner of mental health and the commissioner of the office of addiction services and supports, shall establish a statewide behavioral health crisis technical assistance center within the office of mental health. The commissioners of mental health and the office of addiction services and supports shall be responsible for the structure and operation of the statewide behavioral health crisis technical assistance center. This statewide behavioral health crisis technical assistance center will assist local government units in their emergency and crisis services planning process under paragraph seventeen of subdivision (a) of section 41.13 of this chapter. The statewide behavioral health crisis technical assistance center will provide continuing support to local government units and their crisis response teams as they provide a non-police, community-run public health-based response operating under an approved emergency and crisis services plan.

§ 9. The mental hygiene law is amended by adding a new section 5.08 to read as follows:

§ 5.08 Statewide emergency and crisis response council.

(a) There is hereby created in the department the statewide emergency and crisis response council to work in conjunction with the commissioner of mental health and the commissioner of the office of addiction services and supports to jointly approve emergency and crisis services plans submitted by one or more local government units, and provide supports on matters regarding the operation and financing of high-quality emergency and crisis services provided to persons experiencing a mental health, alcohol use or substance use crisis.

(b) Four members of the state council shall be appointed by the governor. Sixteen members of the council shall be appointed by the state legislature, as follows: (1) four members shall be appointed by the speaker of the assembly; (2) four members shall be appointed by the temporary president of the senate; (3) one member shall be appointed by

the minority leader of the assembly; (4) one member shall be appointed by the minority leader of the senate; (5) two members shall be appointed by the chairperson of the assembly committee on mental health; (6) two members shall be appointed by the chairperson of the senate committee on mental health; (7) one member shall be appointed by the ranking minority member of the assembly committee on mental health; and (8) one member shall be appointed by the ranking minority member of the senate committee on mental health. The membership shall consist of at least fifty-one percent peers and family peers. The entire statewide emergency and crisis response council shall reflect the state's diversity of race, age, language, national origin, ethnicity, geography, and disability. At least one-third of the council shall have demonstrated certification, training, or employment in culturally competent responses to mental health, alcohol use or substance use crises. Every person appointed to the council shall have demonstrated knowledge of, and skills in, culturally competent provision of trauma-informed mental health, alcohol use, and substance use crisis response services. Each member of the council shall be a family peer; licensed mental health or addiction clinician; a licensed mental health or addiction counselor; a licensed physician, nurse, or mental health or addiction provider; a mental health or addiction counselor; a representative of a not-for-profit disability justice organization; an emergency medical technician; or a crisis health care worker.

(c) The members of the council, upon securing a quorum, shall elect a chairperson from among the members of the council by a majority vote of those council members present.

(d) The term of office of members of the council shall be four years, except that of those members first appointed, at least one-half but not more than two-thirds shall be for terms not to exceed two years. Vacancies shall be filled by appointment for the remainder of an unexpired term. The council members shall continue in office until the expiration of their terms and until their successors are appointed. No council member shall be appointed to the council for more than four consecutive terms.

(e) The council shall advise, oversee, assist and make recommendations to the commissioners on specific policies and procedures regarding the operation and financing of emergency and crisis services which:

(1) ensure a non-police, trauma-informed, and public health-based response to anyone in the state experiencing a mental health, alcohol use, or substance use crisis;

(2) are designed to de-escalate any situation involving individuals experiencing a mental health, alcohol use, or substance use crisis, and which eliminate the use of non-consensual treatment, non-consensual transport, and force;

(3) ensure the most appropriate treatment of individuals experiencing a mental health, alcohol use or substance use crisis;

(4) maximize the use of voluntary assessment and voluntary referral of individuals experiencing a mental health, alcohol use or substance use crisis;

(5) minimize arrest and detention by law enforcement and minimize contact with the criminal legal system for individuals experiencing a mental health, alcohol use, or substance use crisis;

(6) minimize physical harm and trauma for individuals who experience a mental health, alcohol use, or substance use crisis; and

(7) effectively respond to all individuals experiencing a mental health, alcohol use, or substance use crisis with culturally competent care and without regard to source of funding.

(f) The council shall also review emergency and crisis services programs and systems operating within the state or nationally, which could be deployed in this state as model crisis and emergency services systems.

(g) The council shall meet as frequently as its business may require, but no less frequently than four times per year during the first four years of the council's creation, and two times per year subsequently after the first four years. At least one of such meetings per year shall be held in a manner and at a time designed to maximize participation of working members of the public. Meetings of the council shall be governed by the provisions of article seven of the public officers law, and shall be open to and accessible by the public including by video conference or computer to the greatest extent possible.

(h) The presence of twelve voting members of the council, consisting of at least fifty-one percent of peers and family peers, shall constitute a quorum.

(i) The members of the council shall receive no compensation for their services as members, but each shall be allowed the necessary and actual expenses incurred in the performance of their duties under this section, including a reasonable reimbursement rate for travel, lodging, and meals while attending meetings of the council.

§ 10. Subdivision (a) of section 9.41 of the mental hygiene law, as amended by section 4 of part AA of chapter 57 of the laws of 2021, is amended to read as follows:

(a) Any peace officer, when acting pursuant to [~~his or her~~] such peace officer's special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be [~~mentally ill and~~] experiencing a mental health, alcohol use or substance use crisis in the following circumstances:

1. Such person is conducting [~~himself or herself~~] themself in a manner which is likely to result in [~~serious~~] an imminent risk of serious physical harm to [~~the person or~~] other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. Such officer may direct the removal of such person or remove [~~him or her~~] such person to any hospital specified in subdivision (a) of section 9.39 of this article, or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40 of this article, or pending [~~his or her~~] such person's examination or admission to any such hospital or comprehensive psychiatric emergency program, [~~program,~~] temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify:

(i) the appropriate local crisis response team established pursuant to paragraph sixteen of subdivision (a) of section 41.03 of this chapter, if any, and the director of community services or, if there be none, the health officer of the city or county of such action[~~.~~];

(ii) the state police, or the department or force of which the officer is a member and has been requested or directed to respond by a crisis response team under subdivision sixteen of section 41.03 of this chapter;

(iii) a crisis response team which is present on the scene with the officer and is incapacitated or otherwise unable to communicate a request that the officer take custody of the individual; or

2. Such person is conducting themselves in a manner which is likely to result in imminent serious physical harm to themselves as manifested by threats of or attempts at suicide or serious bodily harm, and either:

(i) no crisis response team has been established in the region where the person is; or

(ii) the crisis response team has not arrived to the place where the person is located, and taking the person is necessary to prevent such person from experiencing serious physical injury or death.

3. If a peace officer, when acting pursuant to such peace officer's special duties, or a police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department comes upon an individual experiencing a mental health, alcohol or substance use crisis and the circumstances under this section have not been met, the proper crisis response team shall be notified.

§ 11. Section 9.41 of the mental hygiene law, as amended by chapter 843 of the laws of 1980, is amended to read as follows:

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

(a) Any peace officer, when acting pursuant to [~~his~~] such peace officer's special duties, or a police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be [~~mentally ill and~~] experiencing a mental health, alcohol or substance use crisis in the following circumstances:

1. Such person is conducting [~~himself~~] themselves in a manner which is likely to result in [~~serious harm to himself or others. "Likelihood to result in serious harm" shall mean (1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial~~] an imminent risk of serious physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. Such officer may direct the removal of such person or remove [~~him~~] such person to any hospital specified in subdivision (a) of section 9.39 of this article or, comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40 of this article, or pending [~~his~~] their examination or admission to any such hospital or comprehensive psychiatric emergency program, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify:

(i) the appropriate local crisis response team established pursuant to paragraph sixteen of subdivision (a) of section 41.03 of this chapter, if any, and the director of community services or, if there be none, the health officer of the city or county of such action[~~.~~];

(ii) the state police, department, or force of which the officer is a member has been requested or directed to respond by a crisis response team as set forth in subdivision sixteen of section 41.03 of this chapter;

(iii) a crisis response team which is present on the scene with the officer is incapacitated or otherwise unable to communicate a request that the officer take custody of the individual; or

2. Such person is conducting themselves in a manner which is likely to result in imminent serious physical harm to themselves as manifested by threats of or attempts at suicide or serious bodily harm, and either:

(i) no crisis response team has been established in the region where the person is; or

(ii) the crisis response team did not arrive to the place where the person is located, and taking the person is necessary to prevent such person from experiencing serious physical injury or death.

(b) Such officer may direct the removal of such person or remove such person to any hospital specified in subdivision (a) of section 9.39 of this article or, pending their examination or admission to any such hospital, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify appropriate emergency and crisis response services and the director of community services or, if there be none, the health officer of the city or county of such action.

3. If a peace officer, when acting pursuant to such peace officer's special duties, or a police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department comes upon an individual experiencing a mental health, alcohol or substance use crisis and the circumstances under this section have not been met, the proper crisis response team shall be notified.

§ 12. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025; provided, however, that the amendments to subdivision (a) of section 9.41 of the mental hygiene law made by section ten of this act shall be subject to the expiration and reversion of such section pursuant to section 21 of chapter 723 of the laws of 1989, as amended, when upon such date the provisions of section eleven of this act shall take effect. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART MM

Section 1. The title heading of title 5 of article 41 of the public health law, as amended by chapter 436 of the laws of 1967, is amended to read as follows:

[~~REGISTRATION OF FETAL DEATHS~~] REPORTING OF PREGNANCY LOSS

§ 2. Section 4160 of the public health law, as amended by chapter 436 of the laws of 1967, subdivision 2 as amended and subdivisions 4 and 5 as added by chapter 809 of the laws of 1987 and subdivision 3 as amended by chapter 552 of the laws of 2011, is amended to read as follows:

§ 4160. [~~Fetal deaths; registration~~] Pregnancy loss; reporting. 1. [~~Fetal death~~] Pregnancy loss is defined as [~~death prior to the complete expulsion or extraction from its mother of a product of conception; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles~~] the loss of a pregnancy at any gestation, as confirmed by a health care provider licensed pursuant to title eight of the education law and acting within such health care provider's scope of practice, including spontaneous miscarriage, still birth, or any termination of pregnancy which is consistent with the requirements of article twenty-five-A of this chapter.

2. A pregnancy loss caused by spontaneous miscarriage or still birth shall be registered within seventy-two hours of the pregnancy loss by electronically filing directly with the department of health, a report of such loss.

3. A [~~fetal death~~] pregnancy loss due to an induced termination of pregnancy shall be registered within seventy-two hours [~~after expulsion of such fetus~~] of such pregnancy loss if the individual experiencing the pregnancy loss requests such registration to facilitate disposition of the products of conception in accordance with section forty-one hundred sixty-two of this title, by filing directly with the [~~commissioner~~] department of health, a [~~certificate~~] report of such [~~death~~] loss. [~~In addition, a~~] Such report [~~of fetal death~~] shall be [~~reported~~] limited to the [~~registrar in the district in which the fetal death occurred~~] information strictly necessary to facilitate disposition.

[~~3. For the purposes of this article, a fetal death shall be considered as a birth and as a death except that, for a fetal death, separate birth and death certificates shall not be required to be prepared and recorded, except as provided in section forty-one hundred sixty-a of this title.~~

~~4. Local registrars of each district in which fetal death certificates were filed prior to the effective date of this subdivision shall dispose of such certificates in the manner prescribed by the commissioner.~~

~~5.~~] 4. Notwithstanding any other provision of this chapter, the disclosure of information filed pursuant to this section shall be limited to the [~~mother~~] individual who experienced the pregnancy loss, [~~her~~] such individual's lawful representative and to authorized personnel of the department. Nothing in this section shall prohibit disclosure of deidentified information in compliance with federal reporting requirements.

§ 3. Subdivision 3 of section 4160 of the public health law, as amended by section two of this act, is amended to read as follows:

3. A pregnancy loss due to an induced termination of pregnancy shall be registered within seventy-two hours of such pregnancy loss if the individual experiencing the pregnancy loss requests such registration to facilitate disposition of the products of conception in accordance with section forty-one hundred sixty-two of this title, by electronically filing directly with the department of health, a report of such loss. Such report shall be limited to the information strictly necessary to facilitate disposition.

§ 4. Section 4160-a of the public health law, as added by chapter 552 of the laws of 2011, is amended to read as follows:

§ 4160-a. Certificate of still birth. 1. The department, or in the city of New York, the [~~board~~] New York city department of health and mental hygiene, shall establish a certificate of still birth. [~~The registrar with whom a fetal death certificate is filed~~] The department, or in the city of New York, the New York city department of health and mental hygiene, shall issue a certificate of still birth [~~to the parent or parents named on a fetal death certificate issued in the case of a stillbirth,~~] upon the request of such parent or parents who experienced the still birth. If both parents are deceased at the time of the [~~stillbirth~~] still birth, the [~~registrar~~] department, or in the city of New York, the New York city department of health and mental hygiene shall issue the certificate to, and upon the request of, the lawful estate representative, the sibling, parent, or parents of the [~~birth~~] parents.

2. A certificate issued pursuant to this section shall include such appropriate information as shall be determined by the department or if the stillbirth occurred in the city of New York, by the [~~board~~] **New York city department** of health **and mental hygiene**, and shall be on a form established by the department or [~~city of~~] New York [~~board~~] **city department** of health **and mental hygiene** which is similar, as applicable, to the form of a certificate prescribed by section forty-one hundred thirty of this article relating to a live birth. **The department, or in the city of New York, the New York city department of health and mental hygiene, shall provide for the submission of such form through electronic means.**

3. [~~A person who prepares a fetal death certificate pursuant to section forty-one hundred sixty of this title or, if the stillbirth occurred in the city of New York, pursuant to the New York City health code, or their designee, shall inform,~~] **The provider attending the still birth or such provider's designee shall inform the parents** in writing, [~~the parent or parents of a stillborn fetus~~] of the right to receive a certificate of still birth. Provided, however that if both parents are deceased at the time of such stillbirth, then the person shall so inform the **lawful estate representative,** sibling, parent or parents of the [~~birth~~] parent or parents.

4. The person who prepares a **request for a** certificate pursuant to this section shall include thereon the name given to the stillborn fetus by the parents, if the parent or parents wish to include such name on such certificate.

5. A certificate issued pursuant to this section shall not constitute proof of a live birth. Furthermore, such certificate shall not be used to calculate live birth statistics.

6. Notwithstanding any other provision of this chapter, the parent or parents may elect to have the disclosure of and access to the information included on such certificate limited to the parents named on the certificate, their lawful representatives, to authorized personnel of the department, [~~and to the registrar~~] **or, in the city of New York, personnel of the New York city department of health and mental hygiene**.

7. For the purposes of this section, the term "stillbirth" shall mean the [~~unintended~~] intrauterine death of a fetus that occurs after the clinical estimate of the twentieth week of gestation.

8. A certificate of still birth may be requested and issued regardless of the date on which the [~~fetal death~~] **pregnancy loss** certificate was issued.

9. The [~~registrar~~] **department, or in the city of New York, the New York city department of health and mental hygiene** may charge a fee for the issuance of a certificate under this section equal to the fee authorized by law for the certification of a birth or death.

10. This section shall apply to the city of New York, notwithstanding section forty-one hundred four of this article. [~~For the purposes of this section, in relation to the city of New York, the term "registrar" shall mean the official of the city of New York with whom fetal death certificates are filed.~~]

§ 5. Section 4161 of the public health law, as amended by chapter 436 of the laws of 1967, the section heading and subdivisions 2 and 3 as amended by chapter 153 of the laws of 2011, subdivisions 1 and 4 as amended by chapter 352 of the laws of 2013, is amended to read as follows:

§ 4161. [~~Fetal death~~] **Pregnancy loss** certificates; form and content; [~~physicians, nurse practitioners, midwives, and hospital administrators~~]

health care professionals and hospital administrators. 1. The certificate of [~~fetal death~~] on;pregnancy loss and the report of [~~fetal death~~] pregnancy loss shall contain such information and be in such form as the commissioner may prescribe; provided however that commencing on or after the implementation date under section forty-one hundred forty-eight of this article, information and signatures required by this subdivision shall be obtained and made in accordance with section forty-one hundred forty-eight of this article, except that unless requested by the [~~woman~~] individual who experienced the pregnancy loss neither the certificate nor the report of [~~fetal death~~] pregnancy loss shall contain the name of the [~~woman~~] individual, [~~her~~] such individual's social security number or any other information, alone or in combination, which would permit [~~her~~] such individual to be identified except as provided in this subdivision. The report shall state that a certificate of [~~fetal death~~] pregnancy loss was filed with the commissioner and the date of such filing. [~~The commissioner shall develop a unique, confidential identifier to be used on the certificate of fetal death to be used in connection with the exercise of the commissioner's authority to monitor the quality of care provided by any individual or entity licensed to perform an abortion in this state and to permit coordination of data concerning the medical history of the woman for purposes of conducting surveillance scientific studies and research pursuant to the provisions of paragraph (j) of subdivision one of section two hundred six of this chapter.~~]

2. In each case where a [~~physician or nurse practitioner~~] health care provider licensed pursuant to title eight of the education law and acting within the scope of such health care provider's practice was in attendance at or after a [~~fetal death~~] pregnancy loss, it is the duty of such [~~physician or nurse practitioner~~] health care provider to certify [~~to~~] the [~~birth and to the cause of death on the fetal death~~] pregnancy loss certificate. [~~Where a nurse-midwife was in attendance at a fetal death it is the duty of such nurse-midwife to certify to the birth but, he or she shall not certify to the cause of death on the fetal death certificate.~~]

3. [~~Fetal deaths~~] Pregnancy losses occurring without the attendance of a [~~physician or nurse practitioner~~] health care provider as provided in subdivision two of this section shall be treated as [~~deaths~~] occurring without medical attendance, as provided in this article.

4. When a [~~fetal death~~] pregnancy loss occurs in a hospital, except in those cases where certificates are issued by coroners or medical examiners, the person in charge of such hospital or [~~his or her~~] such person's designated representative shall ensure that the certificate is promptly [~~present the certificate to the physician or nurse practitioner in attendance, or a physician or nurse practitioner acting in his or her behalf, who shall promptly certify to the facts of birth and of fetal death, provide the medical information required by the certificate, sign the medical certificate of birth and death, and thereupon return such certificate to such person, so that the seventy-two hour registration time limit prescribed in section four thousand one hundred sixty of this title can be met; provided, however that commencing on or after the implementation date under section forty-one hundred forty-eight of this article, information and signatures required by this subdivision shall be obtained and made in accordance with section forty-one hundred forty-eight of this article~~] prepared in accordance with the provisions of this article and regulations as promulgated by the commissioner.

§ 6. Section 4163 of the public health law, as added by chapter 589 of the laws of 1991, is amended to read as follows:

§ 4163. Penalties. Any person who shall release information which might disclose the identity of the [~~woman~~] pregnant person in connection with a certificate of [~~fetal death~~] pregnancy loss or report of [~~fetal death~~] pregnancy loss in violation of the provisions of this title shall be subject to a civil penalty not to exceed five thousand dollars for each such release. Such penalty may be recovered in the same manner as the penalty provided in section twelve of this chapter.

§ 7. Section 4162 of the public health law, as amended by chapter 809 of the laws of 1987, is amended to read as follows:

§ 4162. [~~Fetal deaths~~] Products of conception; burial and removal; permits. 1. [~~A~~] Upon request a permit shall be [~~required~~] issued for the removal, transportation, burial or other disposition of [~~remains resulting from a fetal death, other than fetal tissue, hydatidiform mole or other evidence of pregnancy recovered by curettage or operative procedures or other products of conception of under twenty weeks uterogestation~~] products of conception.

2. Such permit shall be issued by the local registrar of the district in which the [~~fetal death~~] pregnancy loss occurred upon [~~presentation~~] request by the funeral director [~~of a report of fetal death~~] seeking to take possession of the products of conception, on the form prescribed by the commissioner. The issuance of such permit shall be subject to the provisions of title IV of this article.

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025; provided, however that the amendments to subdivision 2 of section 4160 of the public health law made by section two of this act shall expire and be deemed repealed September 30, 2026, when upon such date the provisions of section three of this act shall take effect.

PART NN

Section 1. The public health law is amended by adding a new article 25-AA to read as follows:

ARTICLE 25-AA

NEW YORK STATE ABORTION CLINICAL TRAINING PROGRAM ACT

Section 2599-bb-10. Policy and purpose.
2599-bb-11. Definitions.
2599-bb-12. Establishment of the New York state abortion clinical training program.
2599-bb-13. Reporting.

§ 2599-bb-10. Policy and purpose. 1. New York has long held that comprehensive reproductive health care is a fundamental component of every individual's health, privacy and equality, and that access to reproductive health care services is integral to their ability to choose to carry a pregnancy to term, to give birth to a child, or to have an abortion.

2. Abortion care is provided in hospitals, clinics, and private medical practices across the state, with a majority of this care delivered by community-based providers. However, growing maternal health care deserts have made it difficult for individuals to access this vital form of care. The need for abortion care continues to increase while the number of providers trained to perform these services is declining. Although there are community-based abortion facilities in every region of the state, only seven out of ten regions have community-based facilities that perform abortion care beyond fifteen weeks of pregnancy. In three regions, only two facilities provide abortion care up to twenty

weeks of pregnancy. This has resulted in pregnant people having to travel further, and in some cases out of state, to access care, especially later in pregnancy.

3. While any physician and health care practitioner licensed by the state with abortion in their scope of practice is authorized to provide this care under law, there is no structured training program available to them for this purpose.

4. New York is in a strong position to address the training needs of these individuals by establishing a statewide abortion clinical training program. There are multiple abortion providers who are experienced, utilize innovative abortion care procedures, and interested in training their peers but require funding to do so.

5. It is the purpose of this article to create new training opportunities for New York health care practitioners in the delivery of abortion care through such a program, thereby protecting every individual's right to health, privacy and equality.

§ 2599-bb-11. Definitions. As used in this article, the following terms shall have the following meanings:

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

2. "Health care services" shall mean the range of care related to the provision of abortion pursuant to section twenty-five hundred ninety-nine-bb of this chapter.

3. "Health care practitioner" shall mean any health care practitioner authorized to provide health care services pursuant to section twenty-five hundred ninety-nine-bb of this chapter or an intern or resident who is employed by a hospital or otherwise enrolled in an accredited graduate medical education program.

4. "Professional educators" shall mean organizations providing reproductive health care, continuing education programs for qualified providers through professional associations or clinical education programs that meet professionally recognized training standards.

§ 2599-bb-12. Establishment of the New York state abortion clinical training program. 1. (a) There is hereby established within the department the New York state abortion clinical training program for the purpose of training health care practitioners in the performance of abortion and related reproductive health care services. The commissioner in consultation with the state education department, shall adopt a comprehensive curriculum and competency based-standards for the training of health care practitioners in the performance of a full range of abortion and related reproductive health care services. Such curriculum and standards shall be consistent with evidence-based training methods and shall include, but not be limited to:

(i) counseling and informed consent;

(ii) miscarriage management;

(iii) patient-centered care;

(iv) pre-abortion evaluation;

(v) contraception and aftercare;

(vi) telehealth delivery;

(vii) procedural abortion;

(viii) medication abortion; and

(ix) potential complications and required care.

(b) The commissioner shall update the adopted curriculum and standards at least every five years.

(c) 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 reflects the needs of abortion providers, abortion funds and consumers in developing the initial curriculum and standards and all subsequent updates.

(d) For professional educators currently operating an abortion clinical training program within the state and selected by the department to facilitate training through the program, the commissioner shall approve the existing curriculum for use in the New York state abortion clinical training program so long as the curriculum meets adopted statewide standards.

3. (a) The commissioner is authorized to enter into agreements with professional educators to facilitate clinical training related to abortion care and other related reproductive health services at a minimum of four sites across the state. In entering such agreements, the commissioner shall consider organizations that:

(i) comply with applicable state laws and regulations;

(ii) are capable of providing culturally congruent care and implicit bias training;

(iii) have demonstrated experience in coordinating abortion care training programs; and

(iv) have sufficient patient volume to accommodate training need.

(b) Professional educators shall not be required to provide training in all areas of the approved curriculum, provided, however, special consideration shall be given to professional educators who have the capability to provide the full range of abortion care and related reproductive health care services.

(c) The commissioner may engage the services of a consultant on a contract basis to support the administration and operation of the program. Such consultant shall be a professional educator that has the demonstrated ability to provide programmatic oversight on a statewide level including, but not limited to candidate selection and screening, and adherence to the approved curriculum and clinical standards.

(d) Each professional educator receiving funding pursuant to this paragraph shall submit a written certification in such form and at such time as the commissioner shall prescribe, attesting how any award made was used to support training health care practitioners in the performance of abortion and related reproductive health care services including, but not limited to the number of health care practitioners selected for training; the number of health care practitioners completing the training; and the areas of the state served by the health care practitioners selected.

(e) Notwithstanding any inconsistent provision of law to the contrary, the commissioner shall be authorized to recoup any award made and determined to have been used in a manner inconsistent with the purposes of the abortion clinical training program. The commissioner is authorized to employ any legal mechanism to recoup such funds, including an offset of other funds that are owed to such professional educator.

4. The commissioner shall prioritize eligible health care practitioners who will provide abortion and related reproductive health care services to underserved communities in the state to receive training.

5. The commissioner shall award and distribute grants to address practical support needs of eligible health care providers. Funds may be awarded to support an eligible health care practitioner in obtaining clinical education on abortion care and other reproductive health services, including, but not limited to, financial support for travel and lodging associated with attending the program.

6. The commissioner shall promulgate rules and regulations as are necessary to carry out the provisions of this section.

7. Nothing in this article shall be construed to limit or restrict abortion training that occurs within New York state separate and apart from the New York state abortion clinical training program.

§ 2599-bb-13. Reporting. The commissioner shall submit a report no later than twelve months after the effective date of this section and annually thereafter, to the governor, the temporary president of the senate and the speaker of the assembly, which shall include, but not be limited to, the total amount of grants issued, the number of eligible participants, the number of eligible providers, and the region of the state where the eligible providers are located. Notwithstanding any other provision of law, the commissioner shall not report any identifying information of eligible participants in the program.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART OO

Section 1. The insurance law is amended by adding a new section 3217-k to read as follows:

§ 3217-k. Primary care spending. (a) Definitions. As used in this section, the following terms shall have the following meanings:

(1) "Overall healthcare spending" means the total cost of care for the patient population of a payor or provider entity for a given calendar year, where cost is calculated for such year as the sum of (A) all claims-based spending paid to providers by public and private payors and (B) all non-claim payments for such year, including, but not limited to, incentive payments and care coordination payments.

(2) "Plan or payor" means every insurance entity providing managed care products, individual comprehensive accident and health insurance or group or blanket comprehensive accident and health insurance, as defined in this chapter, corporation organized under article forty-three of this chapter providing comprehensive health insurance, entity licensed under article forty-four of this chapter providing comprehensive health insurance, every other plan over which the department has jurisdiction, and every third-party payor providing health coverage.

(3) "Primary care" means integrated, accessible healthcare, provided by clinicians accountable for addressing most of a patient's healthcare needs including (A) developing a sustained partnership with patients; (B) practicing in the context of family and community; and (C) coordinating patients' care, which for the purposes of this section shall only include care coordination efforts undertaken by the clinicians rendering healthcare services to a patient and shall not include separate care coordination activities undertaken by a payor.

(4) "Primary care services" means services provided in an outpatient, non-emergency setting by or under the supervision of a physician, nurse practitioner, physician assistant, or midwife, who is practicing general primary care in the following fields, including as evidenced by billing and reporting codes: family practice; general pediatrics; primary care internal medicine; primary care obstetrics; or primary care gynecology. Behavioral or mental health and substance use disorder services are included in primary care services when integrated into a primary care setting, including when provided by a behavioral healthcare psychiatrist, social worker or psychologist. Primary care services shall not include inpatient services, emergency department services, ambulatory

surgical center services, or services provided in an urgent care setting that are billed with non-primary care billing and reporting codes.

(5) "Primary care spending" means any expenditure of funds made by third party payors, public entities, or the state, for the purpose of paying for primary care services directly or paying to improve the delivery of primary care. Primary care spending includes all payment methods, such as fee-for-service, capitation, incentives, value-based payments or other methodologies, and all non-claim payments including but not limited to incentive payments and care coordination payments. For payees that own and/or operate facilities, entities, or other providers, such as health systems or hospital systems, that provide other medical services in addition to primary care, only those funds that are separately documented as funds designated for primary care services shall be considered primary care spending. Any spending shall be adjusted appropriately to exclude any portion of the expenditure that is reasonably attributed to inpatient services or other non-primary care services.

(b) Reporting. (1) Beginning on April first, two thousand twenty-six, each plan or payor as defined in this section shall annually report to the department the percentage of the plan or payor's overall annual healthcare spending that constituted primary care spending.

(2) Nothing herein shall require any plan or payor to report or publicly disclose any specific rates of reimbursement for any specific primary care services.

(3) No plan or payor shall require any healthcare provider to provide additional data or information in order to fulfill this reporting requirement.

(c) Regulation and publication. (1) The commissioner of health and the superintendent shall each promulgate consistent regulations to carry out the provisions of this section, including but not limited to setting deadlines for the reporting required in this section, and adopting further specific definitions of the primary care services for which costs must be reported under this section, including specific billing and reporting codes.

(2) The department of health and the department shall together provide an annual report to the legislature with a summary of the primary care spending data required in this section, and shall also make the report publicly available on both agencies' websites, no later than three months after the data has been collected. The first annual report shall provide the spending information without identifying any individual payor or plan's primary care spending. Each year thereafter, the report spending data shall be published including information specific to each plan or payor.

(d) Primary care spending. (1) Beginning on April first, two thousand twenty-seven, each plan or payor that reports less than twelve and one-half percent of its total expenditures on physical and mental health is primary care spending, as defined by this section, shall additionally submit to the superintendent a plan to increase primary care spending as a percentage of its total overall healthcare spending by at least one percent each year. Beginning on April first, two thousand twenty-eight and on April first of every subsequent year after such plan has been submitted, and until such time as the plan or payor's reported primary care spending is equal to or more than twelve and one-half percent of that plan or payor's overall healthcare spending, the plan or payor's annual reporting shall include information regarding steps that have been taken to increase its proportion of primary care spending.

(2) The commissioner of health and the superintendent may jointly issue guidelines or promulgate regulations regarding the areas on which primary care spending could be increased, including but not limited to:

(A) reimbursement;

(B) capacity-building, technical assistance and training;

(C) upgrading technology, including electronic health record systems and telehealth capabilities;

(D) incentive payments, including but not limited to per-member-per-month, value-based-payment arrangements, shared savings, quality-based payments, risk-based payments; and

(E) transitioning to value-based-payment arrangements.

(e) Limits on premium increases. Plans or payors shall adopt strategies that improve value and quality of care and shift current spending without increasing total medical expenditures. Spending shifts resulting from compliance with this section shall not result in higher premiums or cost-sharing requirements for insured individuals.

§ 2. The social services law is amended by adding a new section 368-g to read as follows:

§ 368-g. Primary care spending. 1. Definitions. As used in this section the terms "overall healthcare spending", "plan or payor", "primary care", "primary care services" and "primary care spending" shall have the same meanings as such terms are defined in section thirty-two hundred seventeen-k of the insurance law.

2. Reporting. (a) Beginning on April first, two thousand twenty-six, each Medicaid managed care provider under section three hundred sixty-four-j of this title and any payor that provides coverage through Medicaid fee-for-service, as such term is defined in paragraph (e) of subdivision thirty-eight of section two of this chapter, shall annually report to the department the percentage of the provider's overall annual healthcare spending that constituted primary care spending.

(b) Nothing herein shall require any Medicaid managed care provider to report or publicly disclose any specific rates of reimbursement for any specific primary care services.

(c) No Medicaid managed care provider shall require any healthcare provider to provide additional data or information in order to fulfill this reporting requirement.

3. Primary care spending. (a) Beginning on April first, two thousand twenty-seven, and in each subsequent year, each Medicaid managed care provider under section three hundred sixty-four-j of this title and any payor that provides coverage through Medicaid fee-for-service, as such term is defined in paragraph (e) of subdivision thirty-eight of section two of this chapter, that reports less than twelve and one-half percent of its total expenditures on physical and mental health are on primary care spending shall additionally submit to the commissioner a plan to increase primary care spending as a percentage of its total overall healthcare spending by at least one percent each year. Beginning on April first, two thousand twenty-eight, and in each subsequent year thereafter, until twelve and one-half percent of that provider or payor's expenditures are on primary care spending, the payor or provider's annual reporting under this section shall include information on steps that have been taken to increase their proportion of primary care spending.

(b) The commissioner and the superintendent of financial services may jointly issue guidelines or promulgate regulations regarding the areas on which spending could be increased, including but not limited to:

(i) reimbursement;

(ii) capacity-building, technical assistance and training;
(iii) upgrading technology, including electronic health record systems and telehealth capabilities;
(iv) incentive payments, including but not limited to per-member-per-month, value-based-payment arrangements, shared savings, quality-based payments, risk-based payments; and
(v) transitioning to value-based-payment arrangements.
(c) The provisions of this section are subject to compliance with all applicable federal and state laws and regulations, including the Centers for Medicare and Medicaid Services approved Medicaid state plan. To the extent required by federal law, the commissioner shall seek any federal approvals necessary to implement this section, including, but not limited to, any state-directed payments, permissions, state plan amendments or federal waivers by the federal Centers for Medicare and Medicaid Services. The commissioner may also apply for appropriate waivers or state directed payments under federal law and regulation or take other actions to secure federal financial participation to assist in promoting the objectives of this section.
4. Limits on cost increases. Plans or payors shall adopt strategies that improve value and quality of care and shift current spending without increasing total medical expenditures.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART PP

Section 1. Paragraph (c) of subdivision 2 of section 365-a of the social services law, as amended by section 12-a of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(c) out-patient hospital or clinic services in facilities operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provisions thereof requiring an operating certificate or license, including facilities authorized by the appropriate licensing authority to provide integrated mental health services, and/or [~~alcoholism and~~] substance [~~abuse~~] use disorder services, and/or physical health services, and/or services to persons with developmental disabilities, when such services are provided at a single location or service site, or where such facilities are not conveniently accessible, in any hospital located within the state and care and services in a day treatment program operated by the department of mental hygiene or by a voluntary agency under an agreement with such department in that part of a public institution operated and approved pursuant to law as an intermediate care facility for persons with developmental disabilities; and provided, that the commissioners of health, mental health, [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports and the office for people with developmental disabilities may issue regulations, including emergency regulations promulgated prior to October first, two thousand fifteen that are required to facilitate the establishment of integrated services clinics. Any such regulations promulgated under this paragraph shall be described in the annual report required pursuant to section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen. Such services shall include those provided by certified recovery peer advocates when provided by programs certified, licensed or otherwise authorized by the office of addiction services and supports;

§ 2. Paragraph (n) of subdivision 2 of section 365-a of the social services law, as amended by chapter 558 of the laws of 1999, is relettered paragraph (n-1) and amended to read as follows:

(n-1) care, treatment, maintenance and rehabilitation services that would otherwise qualify for reimbursement pursuant to this chapter to persons suffering from [~~alcoholism in alcoholism facilities or chemical dependence~~] substance use disorder, as such term is defined in section 1.03 of the mental hygiene law, in inpatient [~~chemical dependence~~] facilities, services, or programs operated in compliance with applicable provisions of this chapter and the mental hygiene law, and certified by the office of [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports, provided however that such services shall be limited to such periods of time as may be determined necessary in accordance with a utilization review procedure established by the commissioner of the office of [~~alcoholism~~] addiction services and [~~substance abuse services~~] supports and provided further, that this paragraph shall not apply to any hospital or part of a hospital as defined in section two thousand eight hundred one of the public health law. Such services shall include those provided by certified recovery peer advocates when provided by programs certified, licensed or otherwise authorized by the office of addiction services and supports.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART QQ

Section 1. The public health law is amended by adding a new section 507 to read as follows:

§ 507. Drug checking services program. 1. For purposes of this section, the following terms shall have the following meanings:

(a) "Enhanced drug checking services" means the utilization of all forms of drug testing equipment including complex technology or equipment designed to analyze substances and provide results at point of testing or point of care, which may include but is not limited to, chemical screening devices such as infrared spectrophotometers, raman spectrophotometers, or ion mobility spectrometers.

(b) "Public health surveillance" means the continuous and systematic collection, analysis, and interpretation of data needed for the planning, implementation, and evaluation of public health initiatives. Public health surveillance may be used for the following purposes:

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

(ii) to document the impact of an intervention;

(iii) to track progress towards specific goals;

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

(v) to inform the public health policy and practices.

2. The department shall:

(a) establish a program to authorize a county or municipality or other entity to provide enhanced drug checking services to assist individuals in determining whether a drug or controlled substance contains contaminants, toxic substances, or hazardous compounds; and

(b) establish public health surveillance of the unregulated drug supply to monitor trends and the impact on health outcomes and increase public awareness of new substances in the unregulated drug supply.

3. Enhanced drug checking services programs shall follow all policies established by the department and submit data in accordance with policies established by the department.

4. The department shall develop policies and procedures to:

(a) authorize enhanced drug checking service delivery;

(b) utilize enhanced drug checking technology for public health surveillance;

(c) develop requirements for technician training to ensure accurate point-of-testing and point-of-care results;

(d) identify appropriate equipment to use; and

(e) establish reporting processes.

5. Employees, contractors, and volunteers of the department, directors, managers, employees, contractors, and volunteers of an entity providing drug checking services, owners of properties where drug checking services occur, counties, municipalities, or other entities authorized by the department, 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 enhanced drug checking services, in accordance with established protocols, shall not be subject to:

(a) arrest, charges, or prosecution pursuant to article thirty-three of this chapter 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 authorized drug checking services unless such conduct was performed in a negligent manner or in bad faith.

6. The department and entities authorized by the department shall not collect, maintain, use, or disclose any personal information relating to an individual from whom the department or other authorized entity receives any drug or substance for checking or disposal.

7. The result of any test carried out by the department or an authorized entity 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.

8. The commissioner shall promulgate such rules and regulations as are necessary to effectuate the provisions of this section.

§ 2. Paragraph (c) of subdivision 1 of section 3305 of the public health law, as amended by chapter 547 of the laws of 1981, is amended, paragraph (d) is relettered paragraph (e), and a new paragraph (d) is added to read as follows:

(c) to temporary incidental possession by employees or agents of persons lawfully entitled to possession, or by persons whose possession is for the purpose of aiding public officers in performing their official duties[~~.~~]; or

(d) to employees, contractors, and volunteers of the department, directors, managers, employees, contractors, and volunteers of an entity providing drug checking services authorized under section five hundred seven of this chapter, owners of properties where such authorized drug checking services occur, counties, municipalities, or other entities authorized by the department, 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 authorized drug checking services, in accordance with established protocols; or

§ 3. This act shall take effect on the ninetieth day after it shall have become a law. Effective immediately, the addition, amendment, and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART RR

Section 1. The public health law is amended by adding a new section 2557-a to read as follows:

§ 2557-a. Early intervention program review. 1. The commissioner shall conduct a comprehensive study and review of the early intervention program including the models of service delivery and the rates of reimbursement for each such service and model made through the early intervention program for efficacy, adequacy and effectiveness of service delivery and the full implementation of individualized family service plans. The review shall include:

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

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

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

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

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

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

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

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

2. Such review shall also include an assessment of the efficacy of program models for the provision of early intervention services, including, but not limited to group services, individual services, facility based services and home-based services and the configurations of such service models. Such review shall include a comprehensive assessment of the utilization of each model and configuration, including barriers to fuller utilizations, and utilization disaggregated by clinical service.

3. Within one year after the effective date of this section, the commissioner shall submit a report of the findings and recommendations under this section to the governor, the temporary president of the

senate, the speaker of the assembly, and the chairs of the senate and assembly committees on health, and shall post the report on the department's website.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART SS

Section 1. Paragraph (gg) of subdivision 2 of section 365-a of the social services law, as amended by chapter 97 of the laws of 2022, is amended to read as follows:

(gg) care and services provided by mental health counselors [~~and~~], marriage and family therapists, and creative arts therapists licensed pursuant to article one hundred sixty-three of the education law acting within their scope of practice, where such services would otherwise be covered under this title. Nothing in this paragraph shall be construed to modify or expand the scope of practice of a mental health counselor [~~or~~], marriage and family therapist, or creative arts therapist licensed pursuant to article one hundred sixty-three of the education law.

§ 2. This act shall take effect on the ninetieth day after it shall have become a law.

PART TT

Section 1. The public health law is amended by adding two new sections 2999-k and 2999-l to read as follows:

§ 2999-k. Medical indemnity fund ombudsperson. 1. There is hereby established an office of the state medical indemnity fund ombudsperson for the purpose of receiving and resolving complaints affecting qualified plaintiffs, where appropriate, referring such complaints to the appropriate agencies and acting in concert with such agencies. The commissioner shall appoint a full-time medical indemnity fund ombudsperson to administer and supervise the office of the state medical indemnity fund ombudsperson. The medical indemnity fund ombudsperson shall be selected from among individuals with expertise and experience in the field of neurological injuries and advocacy, and with such other qualifications as shall be determined by the commissioner. Such ombudsperson may, with approval of the commissioner, appoint one or more authorized deputies to assist in their duties pursuant to this section; provided, however, that no such deputy shall have any conflict of interest, or be employed by the fund administrator or other party involved in the management of the fund. The medical indemnity fund ombudsperson shall, personally or through authorized deputies:

(a) identify, investigate and resolve complaints that are made by or on behalf of qualified plaintiffs, and that relate to actions, inactions or decisions that may adversely affect the health, safety, welfare or rights of qualified plaintiffs;

(b) provide services to assist qualified plaintiffs, or their representatives, in navigating the fund and understanding the fund's regulations, guidelines and procedures;

(c) inform qualified plaintiffs, or their representatives, of their rights and means of obtaining the services, supplies and modifications to which they are entitled;

(d) analyze and monitor implementation of the laws and regulations relating to the fund; and

(e) carry out other such activities as the commissioner shall determine appropriate.

2. Neither the medical indemnity fund ombudsperson, nor any of their deputies shall disclose to any person outside the office of the state medical indemnity fund ombudsperson any information obtained from a qualified plaintiff's records without the consent of the qualified plaintiff or their representative.

3. Within one year of the effective date of this section, and annually thereafter, the medical indemnity fund ombudsperson shall submit to the commissioner, the speaker of the assembly and the temporary president of the senate, a report which shall include, but not be limited to, a detailed summary of the activities of the office of the state medical indemnity fund ombudsperson, data regarding the complaints and issues within the fund, the process used in resolving issues, and recommendations for legislative or regulatory amendments to improve the fund.

§ 2999-l. Medical indemnity fund advisory panel. There is hereby established an advisory panel to be comprised of the commissioner, qualified plaintiffs or representatives of qualified plaintiffs, physicians, medical suppliers, advocates and other interested parties. The advisory panel shall be chaired by the commissioner and shall be composed of not less than nine additional members appointed by the governor, of which two shall be appointed upon recommendation of the temporary president of the senate and two shall be appointed upon the recommendation of the speaker of the assembly. The advisory panel shall meet biannually, with the first meeting occurring within one hundred eighty days of the effective date of this section, to discuss the functioning of the fund and any relevant issues. The commissioner shall consider the input and comments of the advisory panel in drafting and amending regulations, guidelines or policies pertaining to the fund administration.

§ 2. This act shall take effect on the ninetieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART UU

Section 1. 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 tele-

phone 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.

§ 2. 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, as amended by section 5 of part B of chapter 57 of the laws of 2024, 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, [~~2026~~] **2028**.

§ 3. This act shall take effect immediately; provided however, that the provisions of section one of this act shall take effect April 1, 2026; provided further, however, that the amendments to subdivision 1 of section 2999-dd of the public health law made by section one of this act shall not affect the expiration of such subdivision and shall expire and be deemed repealed therewith.

PART VV

Section 1. Subdivision 3 of section 364-j of the social services law is amended by adding a new paragraph (d-4) to read as follows:

(d-4) 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.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025; provided, however, that the amendments to section 364-j of the social services law made by this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART WW

Section 1. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (f-1) to read as follows:

(f-1) including but not limited to dental implants, implant-related services, dental prosthetic appliances, replacement dental prosthetic appliances, crowns and root canals for posterior and anterior teeth,

crown lengthening when associated with a covered crown and/or root canal if a qualified dentist authorizes the procedures;

§ 2. This act shall take effect on the ninetieth day after it shall have become a law.

PART XX

Section 1. Section 2 of chapter 769 of the laws of 2023, amending the public health law relating to the adult cystic fibrosis assistance program, as amended by section 14 of part B of chapter 57 of the laws of 2024, is amended to read as follows:

§ 2. This act shall take effect immediately and shall expire March 31, [~~2025~~] **2030** when upon such date the provisions of this act shall be deemed repealed.

§ 2. This act shall take effect immediately.

PART YY

Section 1. Paragraph (c) of subdivision 5-a of section 2807-m of the public health law, as amended by section 6 of part C of chapter 57 of the laws of 2023, is amended to read as follows:

(c) Physician **and dentist** loan repayment program. One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, one million nine hundred sixty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to one million seven hundred five thousand dollars each state fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician **and dentist** loan repayment in accordance with subdivision ten of this section. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Funding shall first be awarded to repay loans of up to twenty-five physicians who train in primary care or specialty tracks in teaching

general hospitals, and who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to repay loans of physicians **or dentists** who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner, including but not limited to physicians **or dentists** working in general hospitals, or other health care facilities.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed in accordance with subparagraphs (i) and (ii) of this paragraph to physicians **or dentists** identified by general hospitals.

(iv) In addition to the funds allocated under this paragraph, for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(v) In addition to the funds allocated under this paragraph, for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, two million dollars shall be available for the purposes described in subdivision ten of this section;

(vi) Notwithstanding any provision of law to the contrary, and subject to the extension of the Health Care Reform Act of 1996, sufficient funds shall be available for the purposes described in subdivision ten of this section in amounts necessary to fund the remaining year commitments for awards made pursuant to subparagraphs (iv) and (v) of this paragraph.

§ 2. Paragraph (d) of subdivision 5-a of section 2807-m of the public health law, as amended by section 6 of part C of chapter 57 of the laws of 2023, is amended to read as follows:

(d) Physician **and dentist** practice support. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to four million three hundred sixty thousand dollars each state fiscal year for the period April first, two thousand fourteen through March thirty-first, two thousand seventeen, up to four million three hundred sixty thousand dollars for each state fiscal year for the period April first, two thousand seventeen through March thirty-first, two thousand twenty, up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty through March thirty-first, two thousand twenty-three, and up to four million three hundred sixty thousand dollars for each fiscal year for the period April first, two thousand twenty-three through March thirty-first, two thousand twenty-six, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician **and dentist** practice support. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall

be distributed in a manner to be determined by the commissioner without a competitive bid or request for proposal process as follows:

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by physicians **or dentists** trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to physicians **or dentists** to support the cost of establishing or joining practices in underserved communities, as determined by the commissioner, and to hospitals and other health care providers to recruit new physicians **or dentists** to provide services in underserved communities, as determined by the commissioner.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed to general hospitals in accordance with subparagraphs (i) and (ii) of this paragraph.

§ 3. Subdivision 10 of section 2807-m of the public health law, as added by section 75-e of part C of chapter 58 of the laws of 2008, paragraphs (a) and (c) as amended by section 13 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

10. Physician **and dentist** loan repayment program. (a) Beginning January first, two thousand eight, the commissioner is authorized, within amounts available pursuant to subdivision five-a of this section, to make loan repayment awards to primary care physicians **and dentists** or other physician **and dentist** specialties determined by the commissioner to be in short supply, licensed to practice medicine **or dentistry** in New York state, who agree to practice for at least five years in an underserved area, as determined by the commissioner. Such physician **or dentist** shall be eligible for a loan repayment award of up to one hundred fifty thousand dollars over a five year period distributed as follows: fifteen percent of total loan debt not to exceed twenty thousand dollars for the first year; fifteen percent of total loan debt not to exceed twenty-five thousand dollars for the second year; twenty percent of total loan debt not to exceed thirty-five thousand dollars for the third year; and twenty-five percent of total loan debt not to exceed thirty-five thousand dollars per year for the fourth year; and any unpaid balance of the total loan debt not to exceed the maximum award amount for the fifth year of practice in such area.

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

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

(d) The commissioner is authorized to apply any funds available for purposes of paragraph (a) of this subdivision for use as matching funds for federal grants for the purpose of assisting states in operating loan

repayment programs pursuant to section three hundred thirty-eight I of the public health service act.

(e) The commissioner may postpone, change or waive the service obligation and repayment amounts set forth in paragraphs (a) and (c), respectively of this subdivision in individual circumstances where there is compelling need or hardship.

(f)(i) When a physician **or dentist** is not actually practicing in an underserved area, [~~he or she~~] **such physician or dentist** shall be deemed to be practicing in an underserved area if [~~he or she practices~~] **they practice** in a facility or physician's **or dentist's** office that primarily serves an underserved population as determined by the commissioner, without regard to whether the population or the facility or physician's **or dentist's** office is located in an underserved area.

(ii) In making criteria and determinations as to whether an area is an underserved area or whether a facility or physician's **or dentist's** office primarily serves an underserved population, the commissioner may make separate criteria and determinations for different specialties.

§ 4. This act shall take effect immediately.

PART ZZ

Section 1. 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. This act shall take effect January 1, 2026; provided, however, that the effectiveness of sections one and two 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 AAA

Section 1. The public health law is amended by adding a new section 207-b to read as follows:

§ 207-b. Tick-borne illnesses; reports. 1. The department, in conjunction with the tick-borne disease institute and the department of environmental conservation, shall publish a report on its website containing information related to the incidence of tick-borne illnesses in the state. Such report shall include, but not be limited to:

(a) the number of diagnosed cases of tick-borne illnesses;

(b) the incidence of tick-borne illness in each county; and

(c) the estimated tick population in the state and whether such population is expected to increase, decrease, or remain constant at the state and county level.

2. On or before April first annually, the department, in conjunction with the tick-borne disease institute and the department of environmental conservation, shall submit a report to the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate and the minority leader of the assembly. Such report shall summarize the statistics required to be reported pursuant to subdivision one of this section for the previous year and include any other information deemed relevant to tick-borne illnesses for the coming year.

§ 2. (a) The superintendent of financial services, in consultation with the commissioner of health, shall review the status of health insurance coverage for the treatment of Lyme disease and other tick-borne related diseases, and make recommendations regarding potential changes to insurance coverage requirements and parameters. Such review shall include, but not be limited to:

(i) The current range of insurance coverage for the treatment of Lyme and other tick-borne related diseases within New York state;

(ii) Reasons for insurer denial of coverage for the treatment of Lyme and other tick-borne related diseases;

(iii) Insurance coverage required by other states for the treatment of symptoms related to Lyme and other tick-borne diseases and their estimated costs and payment models; and

(iv) The estimated cost of expanding coverage for the treatment of symptoms related to Lyme disease and other tick-borne related diseases.

(b) Within one hundred eighty days of the effective date of this act, the superintendent of financial services shall submit a report to the governor, the temporary president of the senate, and the speaker of the assembly of the findings, conclusions and recommendations of the department of financial services.

§ 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2025.

PART BBB

Section 1. Direct support wage enhancement. 1. Notwithstanding any other inconsistent provision of law, effective April 1, 2025, 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 one hundred twenty-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 four thousand dollars per eligible employee based on the forms developed pursuant to subdivision three of this section.

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

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

PART CCC

Section 1. Section 3 of part KK of chapter 57 of the laws of 2024 amending the public health law relating to the creation of a community doula expansion grant program, and repealing such program upon expiration thereof, 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 April 1, 2024[~~; provided, however, that the provisions of section two of this act shall expire March 31, 2025 when upon such date the provisions of such section shall be deemed repealed~~].

§ 2. This act shall take effect immediately.

PART DDD

Section 1. Paragraph 10 of subdivision (c) of section 25.18 of the mental hygiene law, as amended by chapter 171 of the laws of 2022, is amended to read as follows:

10. On or before November first of each year, beginning one year after the initial deposit of monies in the opioid settlement fund, the relevant commissioners[~~r~~] 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 [~~abuse~~] **use disorders** committee, chair of the assembly alcoholism and drug abuse committee, and the opioid settlement advisory board. Such report shall be presented as a consolidated dashboard and be made publicly available on the respective offices' websites. The report shall, to the extent practica-

ble 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 settlement fund **or other funds received pursuant to a New York opioid settlement sharing agreement**, prior to the receipt of such [~~opioid settlement~~] funds; (ii) how funds deposited in the opioid settlement fund **and other funds received pursuant to a New York opioid settlement sharing agreement** had 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 on and what populations such services or programs served; (C) the main criteria utilized to determine the award, including how the program or service assists to reduce the effects of substance use disorders; (D) an analysis of the effectiveness of the services and/or programs that received opioid settlement funding **or other funds received pursuant to a New York opioid settlement sharing agreement** 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 the service and/or program had on prevention, harm reduction, treatment, and recovery advancements; (E) any relevant information provided by the New York subdivisions pursuant to this section; 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.

§ 2. Subdivision (d) of section 25.18 of the mental hygiene law, as amended by chapter 171 of the laws of 2022, is amended to read as follows:

(d) Limitation on authority of government entities to bring lawsuits. No government entity shall have the authority to assert released claims against entities released by the department of law in a statewide opioid settlement agreement executed by the department of law and the released party on or after June first, two thousand twenty-one. Any action filed by a government entity after June thirtieth, two thousand nineteen asserting released claims against a manufacturer, distributor, [~~or~~] dispenser**, consultant, or related party thereof,** of opioid products shall be extinguished by operation of law upon being released pursuant to such statewide opioid settlement agreement.

§ 3. Section 97-aaaaa of the state finance law is amended by adding a new subdivision 8 to read as follows:

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, in conjunction with the commissioner of health, 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' and the department of health's websites. 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 on and what populations such services or programs served;

(C) the main criteria utilized to determine the award, including how the program or service assists 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 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.

§ 4. This act shall take effect immediately; provided, however that the amendments to section 97-aaaaa of the state finance law made by section three of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART EEE

Section 1. Subparagraph (i) of paragraph (c) of subdivision 1 of section 2828 of the public health law, as amended by chapter 747 of the laws of 2023, is amended to read as follows:

(i) Except as provided in subparagraph (ii) of this paragraph, such regulations shall further include at a minimum that any residential health care facility for which the calculation of total operating revenue, as such term is limited by subparagraph (iii) of paragraph (a) of subdivision two of this section, exceeds total operating and non-operating expenses by more than five percent of total operating and non-operating expenses or that fails to spend the minimum amount necessary to comply with the minimum spending standards for resident-facing staffing or direct resident care, calculated on an annual basis, or for the year two thousand twenty-two, on a pro-rata basis for only that portion of the year during which the failure of a residential health care facility to spend a minimum of seventy percent of revenue on direct resident care, and forty percent of revenue on resident-facing staffing, may be held to be a violation of this chapter, shall remit such excess revenue, or the difference between the minimum spending requirement and the actual amount of spending on resident-facing staffing or direct care staffing, as the case may be, to the state, with such excess revenue which shall be payable, in a manner to be determined by such regulations, by November first in the year following the year in which the expenses are incurred. The department shall collect such payments by methods including, but not limited to, bringing suit in a court of competent jurisdiction on its own behalf after giving notice of such suit to the attorney general, deductions or offsets from payments made pursuant to the Medi-

caid program, and shall deposit such recouped funds into the nursing home quality pool, as set forth in paragraph (d) of subdivision two-c of section twenty-eight hundred eight of this article. Provided further that such payments of excess revenue shall be in addition to and shall not affect a residential health care facility's obligations to make any other payments required by state or federal law into the nursing home quality pool, including but not limited to medicaid rate reductions required pursuant to paragraph (g) of subdivision two-c of section twenty-eight hundred eight of this article and department regulations promulgated pursuant thereto. The commissioner or their designees shall have authority to audit the residential health care facilities' reports for compliance in accordance with this section.

§ 2. Paragraph (a) of subdivision 2 of section 2828 of the public health law, as amended by chapter 27 of the laws of 2024, is amended to read as follows:

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

(i) the capital portion of the Medicaid reimbursement rate;

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

(iii) any grant funds from the federal government for reimbursement of COVID-19 pandemic-related expenses, including but not limited to funds received from the federal emergency management agency or health resources and services administration **and such other one-time federal financial assistance**.

§ 3. This act shall take effect immediately; provided, however, for purposes of distribution of the supplemental payment to qualified not-for-profit facilities authorized by chapter 53 of the laws of 2022, enacting the aid to localities budget, and pursuant to the Medicaid State Plan Amendment 22-0007, this act shall be deemed to have been in full force and effect on and after January 1, 2020.

PART FFF

Section 1. Subparagraph (iii) of paragraph (e) of subdivision 6 of section 4403-f of the public health law, as added by section 5 of part MM of chapter 56 of the laws of 2020, is amended to read as follows:

(iii) The commissioner may not establish an annual cap on total enrollment under this paragraph **for managed long term care rate regions of the state where the ratio of long term service and support utilizers per ten thousand relevant population is less than one thousand,** for plans' lines of business operating under the PACE (Program of All-Inclusive Care for the Elderly) model as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, or that serve individuals dually eligible for services and benefits under titles XVIII and XIX of the federal social security act in conjunction with an affiliated Medicare Dual Eligible Special Needs Plan.

§ 2. This act shall take effect immediately; provided, however, that the amendments to section 4403-f of the public health law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART GGG

Section 1. Section 2826 of the public health law is amended by adding a new subdivision (h) to read as follows:

(h) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner shall, subject to the provisions of this subdivision, grant approval of a temporary adjustment to the non-capital components of rates to eligible not for profit and public skilled nursing facilities in three designated regions in upstate New York, one of which is the greater Rochester area region, who demonstrate to the commissioner a collaborative demonstration program designed to improve nursing home efficiency and quality of care. In addition to the greater Rochester region, which has an established quality collaborative, the commissioner shall select two other regions which apply for such designation and prove, to the satisfaction of the commissioner, that the regions present a collaborative program designed to improve the quality of nursing home care and services.

(i) The commissioner is authorized to make payments pursuant to this subdivision only after approval of criteria for the distribution of funds, to be submitted on behalf of such providers by an independent practice association which will coordinate the distribution of funds under this program. The criteria shall provide for metrics which measure collaboration, financial efficiencies, quality of care, the development of common clinical practices, and enhancement of workplace safety, wellness and effectiveness. The submission shall include a methodology for distribution of funds to the participating nursing facilities, based on meeting the criteria.

(ii) Upon approval by the commissioner of the designated regions, such written criteria shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment and shall include a proposed budget to achieve the goals of the program. No less than thirty million dollars shall be allocated annually to providers described in this subdivision. Should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as lump sum medicaid payments or grants.

(iii) The department shall provide a report on an annual basis to the chairs of the senate finance committee and the assembly ways and means committee, and the senate health and the assembly health committees, which shall include the payment made pursuant to this subdivision and an assessment of the effectiveness of this demonstration program.

§ 2. This act shall take effect one year after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such date.

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